

A 6.3
A 3.29

R 6.39
R 6.39
PEN
P 3.29

McGRAW-HILL SERIES IN NURSING

LUCILE PETRY, *Consulting Editor*

*Nurse-patient Relationships
in Psychiatry*

McGraw-Hill Series in Nursing
LUCILE PETRY, Consulting Editor

BEVERLY · A Psychology of Growth

DEMING · Careers for Nurses

DIEHL AND BOYNTON · Personal Health and Community Hygiene

FADDIS AND HAYMAN · Care of the Medical Patient

FASH · Body Mechanics in Nursing Arts

FASH · Kinesiology in Nursing

GORDON, DENSFORD, AND WILLIAMSON · Counseling in Schools of Nursing

HAMPTON · Nursing of the Sick—1893

HARTWELL · Practical Psychiatry and Mental Hygiene

JAMISON · Solutions and Dosage

KALKMAN · Introduction to Psychiatric Nursing

KOOS · The Sociology of the Patient

NEAL · Chemistry in Nursing

POTTER · Fundamentals of Human Reproduction

RENDER · Nurse-patient Relationships in Psychiatry

WITTON · Microbiology with Applications to Nursing

NURSE-PATIENT RELATIONSHIPS IN PSYCHIATRY

by HELENA WILLIS RENDER, R.N.

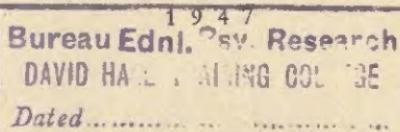
Formerly Supervisor, Neuropsychiatric Division

City Hospital, Cleveland; Chief Nurse

Iowa State Psychopathic Hospital

New York Toronto London

McGRAW-HILL BOOK COMPANY, INC.



616.89
RER

Bureau Ednl. Psy. Research
DAVID HAMILTON COLLEGE
Dated 19-3-55
Accs. No 633

NURSE-PATIENT RELATIONSHIPS
IN PSYCHIATRY

COPYRIGHT, 1947, BY THE
MCGRAW-HILL BOOK COMPANY, INC.

PRINTED IN THE UNITED STATES OF AMERICA

All rights reserved. This book, or parts thereof, may not be reproduced in any form without permission of the publishers.

Foreword

The needs for persons prepared in the fields of psychiatry, psychiatric nursing, and psychiatric social work and for related personnel have mounted to staggering totals. Fortunately, awareness of those needs now also mounts. Many people learned of these needs from reports of Selective Service on causes of rejection of young men otherwise fit for military service; from the percentage of medical discharges from our armed forces which were due to psychiatric causes; and from the requirements for psychiatric care on the part of our veterans. Perhaps even more important was the realization by thousands of members of our armed forces and subsequently by their families that psychiatric attention enabled them to survive the stresses of war.

Our newspapers, magazines, fiction, radio, and movies have contributed to the increase in awareness not only of the extent and intensity of these problems but also of the importance of early diagnosis, prevention, and competent early treatment of psychiatric diseases—a pattern of attack on health problems familiar to nurses. Our people have learned of the vast number of patients hopelessly living out their lives in publicly supported mental institutions. Cheap as their care is—our economies have made it disgracefully poor care—the very number of these patients, current and probable, frightens us lest we not be able to bear the cost in dollars and in human misery. We have long accepted as a public responsibility the care of patients for whom families cannot accept responsibility because of length and nature of illness. Now, with further enlightenment, we understand the wisdom of an investment of money and intelligence to prevent the accumulation of a greater load. We see, too, the other side of the coin—the positive values to our material productiveness and our social welfare of programs which promote the development of happily functioning personalities.

Nurses will be proud to undertake their invaluable role in this most fascinating drama. Student nurses today are taught psychiatric nursing—both its principles and their use in practice—as a functional part of their basic learning. Nurses will receive satisfaction in observing two trends in a better way of solving the

FOREWORD

problems of psychiatric care—one, the concept that psychiatric skills are needed by every doctor and every nurse; the other, that psychiatric care must be made available in general hospitals as well as in hospitals devoted especially to these patients. As nurses and citizens, you will place your force into the development of these trends and will be prepared to support new trends not yet initiated.

This book and your course in psychiatric nursing, which should if possible include experience with psychiatric patients, will open wider the door through which you have already peered with curiosity and interest. Passing through it, you will find a way of caring for patients, even a way of personal living, which calls for spiritual depths, strength of personality, and breadth of scientific and cultural understanding. May you build throughout your life on this foundation of satisfactions from understanding the mystery and miracle of the human personality.

LUCILE PETRY.

Preface

For the past twenty-five years the author has had the privilege of teaching and organizing courses for nurses in the field of psychiatry. Rapid progress has been made in the past few years in this field of teaching. It is now apparent that nurse-patient relationships are fully as important as clinical skills in presenting to student nurses the basic principles of nursing care. This fact is important in psychiatry, but the same principles apply in other clinical subjects as well. There is a definite need for presentation and clarification of nurse-patient relationships and for help on related teaching problems. Hence this book.

Its purpose is to present essential features of the subject. Nursing care is viewed primarily from the standpoint of behavior and nursing needs and is oriented to the patient as a person with the intention of modifying moods and changing attitudes. The entire work deals with the reality and philosophy of nursing rather than with techniques and routines. Many ideas are taken from the field of creative arts and incorporated as an essential part of nursing care. Clinical psychiatry is given a minor place and treated entirely from a nursing point of view. Nursing skills as such are not included.

The primary nursing procedure is considered as the management of the patient in action, the field of operation is looked upon as the manipulation of immediate environmental factors, and the basic need is presented as a sensitivity to subjective aspects of behavior. Principles are presented as part of an intellectual approach to the patient and are built around reason and tolerance. The method of treatment is an attempt to stimulate intelligence and ideals.

The author wishes to thank Dr. William Malamud, Dr. Andrew Woods, Dr. Samuel Hamilton, Mrs. Katharine McLean Steele, and Miss Clara Ellis for specific suggestions, and Mr. Joseph Remenyi for his instruction in literature as an interpretation of life. The author is especially grateful to her husband, Dr. Norman Render, superintendent of the Clarinda State Hospital, for

advice and continual encouragement and for making it possible for her to keep in touch with recent developments in the field of psychiatry.

HELENA WILLIS RENDER.

CLARINDA, IOWA,
December, 1946.

Contents

<i>Foreword by Lucile Petry</i>	v
<i>Preface</i>	vii
I. Psychiatric Nursing: Meaning, Objectives	1
II. Behavior: Observing, Recording, Understanding, Modifying	42
III. Nursing Care: Remedial Approach	88
IV. Nursing Care: Primary Personality Disorders	126
V. Nursing Care: Special Problems	168
VI. Nursing Care: Special Problems, continued	195
VII. Nursing Care: Rehabilitation	228
VIII. Nursing Care: Secondary Personality Changes	259
IX. The Use of Art, Literature, Music	296

APPENDIX

I. Outline for Study of Flaubert's "Madame Bovary"	313
II. Glossary of Terms	321
III. Compositions Written or Transcribed for the Piano	328
IV. List of Visual Aids	334
<i>Index</i>	339

CHAPTER I

PSYCHIATRIC NURSING: MEANING AND OBJECTIVES

THE MEANING OF PSYCHIATRIC NURSING

Mental Illness.—The term “mental illness” refers to a broad field of medicine. In every illness a loss of function or efficiency and interference with normal health activities in life are implied. In general we understand physical and bodily diseases like scarlet fever or tuberculosis; but we must realize that, because of the physical handicap, the mind too suffers some restriction of its normal functions. In a large class of diseases mental symptoms take predominance over the physical and are the first consideration in treatment and care. The symptoms are viewed in relation to the existing culture, and the victims are recognized as a special group and referred to wards or hospitals for the mentally ill.

Such mental disease appears in all gradations, from slight temporary aberrations of thought and behavior to the major disturbances of feeling, thinking, and acting that require the person's segregation from his fellows. The causes of mental illness are obscured by their complexity and the fact that the disease or disorder may spring from a whole series of events, both physical and psychological, rather than from such simple infections or injuries as commonly result in physical illness.

Sometimes the onset of incapacitating symptoms is insidious, having beginnings early in life and progressing along certain lines of development to the recognizable disease picture. Sometimes the onset is sudden and dramatic, relating to a definite life situation that is recognized as the precipitating cause. Sometimes there is a demonstrable pathological condition of the brain, endocrine glands, or body chemistry, but in the largest group of incapacitating mental illnesses no such organic cause has been found in the most careful examinations to date.

Since mental illness is fundamentally a disturbance in the patient's way of life, particularly in his emotional attitudes,

treatment is essentially an interpersonal relationship between the patient and the physician. Sometimes the physician will call on you to take an active part in the central treatment, sometimes he will think it wiser for you to remain quietly in the background and work only on contributory therapeutic factors, but whatever happens he will insist that you do nothing to tear down, or interfere with, the progress the patient is making under treatment. The material that follows is intended to help you realize your proper function in the field of psychiatry and to show its interrelationship with general nursing.

The Patient.—The study of psychiatric nursing pivots around pathological behavior. When you are introduced to psychiatry by means of a "quiet" ward you are impressed with the apparent normal behavior of the patient (so much so that you are inclined to think that there is nothing much wrong) and disconcerted by the lack of strenuous physical activity. When you begin on a "disturbed" ward you are distressed by the noise; puzzled by the patient's difficulty in organizing perception; interested in the twisted attitudes and the narrow, selfish, warped, often incorrect point of view; amazed at the evident self-deception; concerned over the profitless expenditure of energy; fascinated with the dramatic aspect.

Regardless of your initial impression you will observe before long the outstanding characteristics in those who are mentally ill. One of these characteristics is the dominance of emotional reactions—elation, depression, affective indifference, suspiciousness, unwholesome attitudes, and often childish emotional reactions. Among the others are nervous tension, the evidence of fear, and an inflexibility in moods and attitudes. You will also observe that the thinking of the mentally ill is characterized by egocentricity, rigidity, unreasonableness, well-established prejudices, and faulty judgment of values. Not all of these unpleasant and destructive characteristics are evident in each patient, and the same characteristics are seen on the medical and surgical wards; but in the person who is mentally ill these characteristics are more marked, more fixed.

Other noticeable points are that the person is incapacitated—wholly or partially disabled, crippled, impotent, ineffectual. There is an evident absence of satisfaction in living. Finally, there are differences in degree of intellectual control over social behavior.

Before coming to the psychiatric ward, most nurses have the idea that all people who are mentally ill are irrational and do not understand what goes on around them. One of the fundamental ideas to grasp early is that the patient, regardless of his behavior, is a human being who thinks and loves and hates and who has quick and acute sensibilities. At heart he is friendly, good, fine. Pleasant reactions are very near the surface, requiring only the right stimulus. Even with the unwholesome, disagreeable, and sometimes offensive symptoms of illness probably there are more sensitive, noble souls to be found in hospitals for the mentally ill than in any other one place.

All happy patients are alike; every unhappy patient is unhappy in his own way. The overt behavior is an expression of the effort to find peace, and unless there is a physical illness, an interest in his fears, anxieties, uncertainties, hatreds takes precedence over interest in his temperature, pulse, and respiration. Unpleasant, perverse, unreasonable behavior is all a part of the illness and corresponds to the fever, vomitus, and fetid breath of the patient on the medical and surgical ward.

The Nurse. General Qualifications. For psychiatric nursing you should have a working knowledge of the subject matter and certain definite personality characteristics.

Personality factors are stressed because every word and act produces a positive or negative influence on your patient's immediate condition. This influence is indirect, external, and at the periphery of the main problem, but nevertheless it is of consequence. If you are to function in an active, positive way (merely not to offend John Doe or just to get along with him is inadequate), your own reaction to the patient has to be studied and conditioned.

Nurses, like other people, are of two fundamental personality types—those who focus primarily on *people* and those who focus primarily on *things*.

The nurse whose primary interest and best judgment are concerned with people usually radiates a good-natured kindness. She has an emollient quality which makes it easy for her to get along with people and to foster good comradeship in a group. She gains rapport quickly and without conscious effort but is apt to lose it just as rapidly through her character weaknesses, which are apt to be impulsiveness, disregard of detail and dislike of exactitude, impatience with continued effort, and loss of interest

in a project unless there is immediate success. If attention and kindness are not the outcome of energetic thinking, they have a superficial, undependable quality.

Those who focus primarily on people need particularly to stimulate and direct their own thinking, to organize their sensitivities, and to pay more attention to detail, especially to accuracy.

The nurse who is mainly interested in, and who best adjusts herself to, things becomes efficient in making plans for developing programs and in reducing activities to cold routines; she evaluates herself and measures achievement in terms of perfection of detail. Naturally the care of patients whose emotions, impulses, and fantasies need particular attention will suffer under such a technical and purely academic approach. Psychiatric nursing deals with reality, not just with principles. In principle the patient is supposed to expectorate in socially acceptable places; in reality, he may do it elsewhere. The weakness in the character of the nurse who focuses attention on things is apt to lie in her inability to cope with a person who fails to follow out her prescribed routine. To knowledge of administrative routine something else must be added, and that something is the ability to create within her own mind a certain emotional susceptibility, an appreciative mood.

Those who focus primarily on things need particularly to increase their sensitivities, to learn to identify themselves with people, and to make their efficiency less insistent.

Students whose personality characteristics are excessively of one or the other type described above cannot deal satisfactorily with psychiatric patients and should give up the thought of specializing in this field, however well they may succeed in other fields of nursing. In attempting to shift the focus of their characters toward the middle ground that is necessary for successful psychiatric nursing they unfortunately gain nothing but only lose what made them function best in another field.

Specific Qualifications.—Regarding specific qualifications, opinions differ as to details. Although possibly not essential, the following contribute greatly toward mastering theory and practice: emotional maturity, adaptability, sensitive perception and discernment, creative imagination and enthusiasm, inductive reasoning or foresight, and the pioneer spirit.

The first qualification, *emotional maturity*, is important. If you have it, this means that you do not get angry easily and are not

obstinate. It also means that you do not act immediately on impulse but weigh situations objectively. Emotional maturity enables you to make decisions and independent judgments and to accept responsibility for meeting your own needs. In addition, you do not dwell on what other people owe you and are not too concerned with what other people think of you. You relate yourself to others; that is, your first thoughts are "we" rather than "I." You have a capacity to discriminate and respond to goals that are not superficially protective. Finally, if you are emotionally mature you can suffer discomfort for the sake of later greater comfort and can carry insults, anger, disappointment, and grief with equanimity.

If you are not *adaptable* you are useless on a psychiatric ward. The work calls for continual change; no two situations are exactly alike, and routines are at a minimum. The patients' moods and attitudes are rigid, set, and inflexible. If you have similar personality tendencies, progress in the nursing situation is soon stalemates.

You need *sensitive perception* of the patient's feelings in order to understand the patient's inner state, and discernment is necessary to keep your own thoughts and feelings from running wild. Practical problems in psychiatric nursing deal mostly with emotions and feeling states. You meet the stark drama that touches the lives of the masses, deal with tangled emotional crises, and dwell in the midst of people who are desperately unhappy. Much of the time the condition appears like "purification through sorrow," without the purification.

Lacking sensitive perception and discernment, you will judge patients as silly dotes, trying to get sympathy or lacking in will power. This point of view may be true, but it is not sufficiently inclusive and does not take into account the power of emotion in preventing human behavior from operation on a discriminating intellectual basis. Without a capacity for deep feeling and lacking sensitive perception of the patient's feelings, your approach to these human problems will be materialistic and your performance a display of mechanical technique.

The ability to *discern* a patient's feelings and their roots in his mental turmoil will enable you to keep your own thoughts and feeling states in balance, to stand steady under the tongue lashing of an excited patient or the clutching despair of an agitated depressed patient. Possession of such discernment or wisdom,

described by some as knowledge of the art of living, gives you stability and perspective, thereby providing a long-range view in all situations and preventing you from becoming upset over dissatisfactions of the moment.

Two other important qualifications are *creative imagination and enthusiasm*. You should be always a combination of artist and research worker. A great deal of nursing care depends upon ingenuity and a capacity to devise means, develop methods, introduce new ideas or dress up old ones in new ways, often despite opposition and always in the presence of uncertainty and threat of failure.

On a chart you may record a nursing measure "refused," but your obligation and responsibility as a psychiatric nurse are not ended. In fact this is an exact point at which general nursing may stop and psychiatric aspects of care really begin.

Regarding a lack of cooperation in a patient, whether you meet this with doubt and frustration or as a challenge depends largely upon your capacity for creative imagination and enthusiasm. These are basic needs. Without them, who could spend weeks in the face of shifting obstacles trying to get a patient to do some particular thing; see harmony, unity, beauty in the midst of so much discord, inconsistency, ugliness; or even rise above the easy possibility of falling into a rut?

Likewise important is *inductive reasoning or foresight*, especially on a disturbed ward. The lack of this capacity is noticeable in the inexperienced worker.

At first, in dealing with those who are mentally ill you observe a fact; a few days later you observe a second fact related to the first; and gradually, step by step, you build toward an *unfailing conclusion*. This is deductive reasoning. It is a slow, but solid and conservative, approach. For instance, you know from textbook reading and from your observation of patients that excitement in a disturbed patient tends to feed upon itself and whatever irritations and distractions there may be in the environment until the explosive point is reached. The nurse who reasons only by deduction finds herself dealing with explosive situations one after the other because she fails to take appropriate measures to anticipate and ward off such climaxes.

Later on, you will see much more all at once, filter out essentials, recognize that the present state fits into a pattern of similar

situations, and jump immediately to a *probable* conclusion on which you begin to work, *i.e.*, you institute sedative measures before the disturbed patient reaches his explosion. This is inductive reasoning. It is speedy but not safe without a sufficient acquaintance with the subject. For instance, the nurse whose experience with schizophrenic patients leads her to believe that a few days' voluntary starvation is of no great consequence will find herself in disaster if she tries this masterful inactivity on a depressed patient. The undeveloped phase is intuition or a ready insight into surface similarities.

Without knowledge and experience, inductive reasoning is built on quicksand; but if you continue always to stop and analyze each step of each situation, you will find very often that the opportunity to use successful measures is lost. The value of inductive reasoning or foresight shows up in the prevention of accidents and unfortunate ward situations.

A *pioneer spirit* is not necessarily an essential qualification for psychiatric nursing. However, it is required of the nurse who takes part in any effort to institute an intensive therapeutic program in a hospital of the old regime, for this brings about opposition from everyone concerned -personnel, patient, relatives, public.

An intensive therapeutic program is one of continuous constructive activity. The old regime was primarily one of attention to physical ills, personal hygiene, and a routine of inactivity. Inactivity spells doom for the patient, but it has comfortable aspects for workers and relatives. It requires a minimum of effort and holds accidents at a low point.

Except in hospitals with teaching and research programs there is usually only a nucleus of workers trying to establish newer methods. This means that a small group must work with a large group who are acquainted only with the old ideas and do their best to resist change. The resistance is not malicious; any change makes a worker insecure and uncomfortable. Resistance is natural, but it does carry weight and undermines the progressive effort.

Even the patient, at least in the beginning, objects to a program of activity. At any particular moment the very ill patient prefers to be let alone. As with the well person, any attempt to change his way of thinking and doing—even though his way is destroying him—is met with opposition.

For a time the patient is more difficult to manage. There is an increase in aggressive behavior somewhat like that of Saul throwing the javelin at little David who, in an effort to relieve Saul's insomnia, played sweet music. But antagonistic reactions do not continue indefinitely. In his illness the patient's energy spends itself in destructive activity—morbid thoughts and feeling states with associated overt behavior. As the physician's immediate treatment (the fundamental treatment is a physician-patient affair) releases emotional tension, energy is available for constructive use and the patient welcomes opportunities for such activity.

A program of activity brings more complaints from relatives. It seems difficult to appreciate that if John Doe breaks an arm in playing ball he is receiving better care than if he had been sitting all day in a regimented line of rocking chairs, stewing over the past and worrying about the future. Also, if a patient is getting along well with a particular kind of work, such as secretarial duties or housekeeping, relatives immediately demand the patient's release, often for such work at home. Too, there may be public complaint about the increased per-capita cost of equipment and personnel for an active therapeutic program.

The public does not appreciate the therapeutic idea in family-care programs. Sometimes this is interpreted as evasion of responsibility to house and feed the sick in structures built for the purpose.

Local rehabilitation centers are fearful of offering employment assistance to patients on parole or discharged from a hospital for the mentally ill. In passing, it is interesting to note that a patient population is affected by the general economic condition of the country. When workers are needed, the capacities of many patients can be salvaged and the patient more easily placed in the community on an earning basis. In times of depression this therapeutic avenue is blocked.

Public support is held back largely because of a general lack of understanding of the nature of mental illnesses, and misconceptions are so ingrained that it is difficult to replace these with truths. The public does not understand clearly what constitutes a mental illness. Benign primary personality disorders are confused with hopeless cases associated with incurable organic conditions; the social problem of old age is blended with psychiatric problems of youth; the problem of mental deficiency is mistaken for the

problem of mental illness; and "mental illness" and "insanity" are considered synonymous terms. This confusion adversely colors public opinion concerning psychiatry's contribution toward healthful living. It is hoped that the time is not far distant when hospitals for the mentally ill will be viewed as information or service centers for those who are nervous, worried, anxious, unhappy, frightened.

Even in hospitals for the mentally ill many of the employees do not understand the behavior of the patient, and those workers who are close to the patients but uninformed continue to feed public curiosity with wild tales. Much of the patient's behavior is not understandable without intensive study and a knowledge of his personal life. Information on the latter is too sacred for general consumption.

Hospitals cannot open their wards freely to visitors, largely because this would incite the indignation of relatives. Visitors would see and recognize patients other than the one they visited and would go back to the home town and circulate information that relatives are trying to withhold.

The person who could help the most to educate the public—the discharged patient—keeps quiet because the community holds his hospitalization against him. And yet these very people who look upon mental illness as a disgrace have no hesitancy in talking about their "stomach trouble" or "heart trouble," which when investigated often proves to be a physiological expression of anxiety or a mental trouble.

Because of this resistance to an active program of treatment and care, psychiatric nurses still need the pioneer spirit of Dorothea Lynde Dix. Before there are comfortable working conditions in all hospitals for the mentally ill the public has to know more about the problems and needs of these hospitals. Where the hospitals are satisfactory there is still the pioneer task of helping the public to understand the nature of mental illness, its status in relation to other illnesses, the value of psychiatry, and the necessity for a greater knowledge of psychiatry's basic premises.

Nursing Care.—The distinguishing feature of psychiatric nursing is the care of patients with morbid thoughts and feeling states. Your principal function is to modify pathological moods and change unwholesome attitudes, particularly at the point of contact between the patient and the need. You work through

interpersonal relationships but at the periphery of the problem and on an external level as compared with the physician. Nevertheless, you have an active, positive function and exert a substantial influence on the patient's condition of the moment. Psychiatric nursing is a contributory affective therapy.

Pertinent Points.

1. Psychiatric nursing is an attitude.
2. Nursing care is oriented to the patient as a person.
3. The primary procedure is the management of the patient in action.
4. The central problems deal with people, not things.
5. Energy must be channeled into the disciplined observation of the patient's behavior.
6. The behavior of the nurse can modify the conduct of the patient.
7. The key point is the manipulation of the *immediate* environment.
8. The principal need is the development of a creative aspect of care.
9. Reasoning and judgment are the means to success.

Essential Concepts.

1. Care is directed by the physician.
2. The nurse creates therapeutic situations.
3. Care is a continual progressive effort.
4. Care is carried out on a level of health.
5. The nurse herself is a vital part of nursing care.

The physician directs all activities with the patient. Nursing care is guided by orders for specific routines and treatments and by conferences regarding interpersonal relationships. Orders for procedures that relate to established treatments are definite; orders concerning interpersonal relationships are usually verbal, in the form of suggestion or advice, and provide considerable latitude for experimentation.

Psychiatric nursing is not unique; the details are common to all good nursing. Yet when a patient in a general hospital becomes mentally ill, how many nurses realize that they can offer the patient everything that nurses in a hospital for the mentally ill can, except perhaps a window out of which he cannot escape?

Nursing activities that make up the care of a patient with a mental illness are the same as for patients in a general hospital, namely, immediate personal needs, ward routines and therapeutic measures, family and community matters, and organization and management of environment.

The truly psychiatric aspect of care resides in the last division—organization and management of environment, particularly in the creation of situations that dissolve distrust, dispel fear, assuage resentment, reduce petulance, take the nettle out of anger, make contention sweet and pleasurable, lessen negative attitudes, lighten despair, comfort those with anxieties, prevent unnecessary or cumulative irritations, preclude needless displeasures and inconveniences, displace loneliness, promote relaxation and rest, engender friendly sentiments, fix a relationship of mutual confidence, win cooperation, renew hope, utilize interests, make reality satisfying, increase security, establish the patient's faith in himself. In short, yours is the responsibility for the creation of situations that soothe, refresh, and restore the spirit of the patient.

Nursing care, like treatment, is a continual progressive effort. Physicians do not limit therapy to stated interviews. They *live* therapy. A doctor does not help a patient adjust to a particular problem and then in passing give a thoughtless answer just to brush him aside. When a patient loses faith in a worker he is worse off than before because he discovers that the worker is among those against whom he must protect himself.

In dealing with the patient you do not use little bits of energy now and then. You have to think continually. Within your own mind you establish immediate and ultimate nursing objectives, consider suggestions and associations that give meaning to the patient's behavior of the moment, and plan a way to get the patient's state of feeling in line with the need.

Nursing objectives come from physicians' orders and classroom studies; suggestions and associations that lend meaning to the patient's behavior come from all past experience, from textbook material, and particularly from your own knowledge of the patient as a person, especially his way of reacting. Getting the mood or the attitude of the patient in line with the need is something you learn by yourself for yourself. In other words, all previous related ideas are marshalled together, and from these you arrive at a conclusion that pushes you forward toward a definite line of conduct,

The process is creatively energetic. Teachers furnish skeletal ideas but you mold your own tools. Clarity, certainty, exactness come from within. Ideas that will prove of value are not yours until you have thought about them, used them, and sensed them just as surely as you sense the color red or the smell of onions. Successful methods are cumulative and conservative. A capacity for dealing with the psychiatric patient is developed by practice, but at best the work is imperfect and subject to improvement. The outstanding features of your effort are the organization of your own energy toward a desired result and the continual intrinsic activity.

In dealing with the patient, view him as having healthy potentialities and treat him as though he were normal. Talk and consult with those who do not respond; never call a middle-aged man "Harry" because he behaves like a child. These patients have normal sensibilities—if anything sensitivities are increased—and they usually understand, or will understand, before it is evident in their behavior.

The care of patients with scarlet fever is much the same for all, but in dealing with those who are mentally ill the particular illness is less important than the available energy and effectual assets. The critical question becomes "How well is the patient?"

Regardless of basic principles in dealing with types of mental reactions, immediate care depends largely on the particular level of behavior at the time. The patient who is in a state of high excitement is not served meals with damask linen and Haviland china or chosen as a partner for a game of chess, but, as his condition warrants, such furnishings and activities are introduced.

Increased privileges mean more independence, but every gain in personal freedom is accompanied by responsibility and obligation. Reality has unpleasant sides. Even in the hospital the patient is not spared *necessary* inconveniences and distress. Otherwise the place would become such a haven of comfort that no patient would want to get well and leave it. How much discomfort should be tolerated is directed by the physician; also, the particular ward in which the patient resides is a factor in this special problem.

Regarding care, anything that intensifies the sense of immediate living has value. The inactive patient is not allowed to sit and stew in his hatreds, agonies, and discouragements; the overactive patient is kept from running himself to exhaustion; all patients are

given responsibilities and pleasure in keeping with their capacities and interests. The physician's orders and suggestions indicate the patient's state of health. Your function is to *create* situations that provide an opportunity for wholesome, balanced activity at the patient's maximum level.

Some of the reasons why it is difficult to grasp central ideas in psychiatric nursing are the larger range of possibilities, the greater degree of individual differences, the additional freedom for action, and the inability to escape dealing with the patient as a person. It is very easy to be afraid of the labor and doubtful of the reward.

In general, the program of care is on a level of health. A quiet-hospital-zone atmosphere is removed. The place is made alive. Life at its best from every aspect—physical, mental, social, spiritual—is made a part of the patient's environment.

In all patient-nurse relationships you inject an inescapable influence. This influence is for good when you are a mature, generous, humble, understanding individual with a stable and wholesome underlying personality structure and a personal quality that rises above irritation, resentment, pettiness, and a narrow point of view.

Your outstanding nursing activity is matching the patient's wit, skill, and ingenuity—often with the odds against you. Problems are filled with human aspects. You must be able to appraise human values and recognize subjective behavior processes. Principles can be taught, but the subject matter cannot be mechanized; poetry and sentiment have a very real place. Scientific techniques are ineffective unless supplemented by insight, conscience, and wisdom. Methods depend less on drugs and the manipulation of equipment than on spirit, attitudes, values, and sensitivities put to work and turned into a useful social practice. You are not merely a dispenser of care; you are a vital part of it.

Outstanding Practical Problem.—The principal practical problem is to determine what primary procedure to follow in dealing with the patient in action. The difficulties encountered will be associated with the seemingly unpredictable characteristic in the behavior (unpredictable until you have dealt with the patient for some time), the rigidity in the mood and the way the patient rejects what is not congenial with this mood, the consistent negative reactions which make you the prime mover in all efficacious patient-nurse relationships. Difficulties are encountered also

in the management of the patient's emotional needs. The whole problem is enhanced by the fact that preparing detailed care in advance is impracticable.

Nursing Activities.—These are of three kinds: direct, immediate, and those extending over a long period.

Your *direct activities* relate to carrying out a specific order. The matter of first importance is definitely and clearly established by the order. The primary responsibility falls on a nurse—the one in charge of the ward—who knows what to do and how to meet the practical problems. For the most part these particular activities are associated with ward routines and diagnostic and therapeutic measures.

In all direct activities a positive, straightforward approach holds supremacy in the control of the situation. The specific order is carried out by one, two, three, or more nurses, depending upon the need, with kindness but with dispatch, regardless of the patient's mood or attitude of the moment.

As every contact has its influence on the patient, attention is given to principles for modifying moods and changing attitudes; the procedure, however, is not delayed by spending time on this particular angle. If several nurses are needed, each one should know her particular part in the total situation and refrain from making unnecessary remarks to the patient or to another nurse, thus dissipating the value of what needs to be said.

Any single contact with a patient in which you speak or act without specific advice is an *immediate activity*. Such activities are numerous, for you constantly answer questions and talk with patients without first having someone place a stamp of approval on what you intend to say.

Although everything you do or say influences the patient's immediate condition, you cannot always be sure in advance how best to handle most of these immediate activities. No book can tell you how to deal with John Doe on every occasion. The John Does are not alike, and, almost without exception, in each situation something quite different has to work itself out in your mind. You examine the situation and organize your own behavior into action toward intellectually determined ends; your judgment, however, cannot be better than the information at hand.

Mr. J. was a withdrawn inhibited type of person. After several months of treatment and care his first industrial occupation was sweeping a

corridor. His inhibitions had broken down to the point that he whistled as he worked. That was real progress. Hearing him whistle, an inexperienced nurse hurried to the patient and said, "Sh-sh, don't whistle; you are in a hospital." The patient stopped whistling, later he stopped sweeping, and still later he broke several panes of glass.

During her convalescence Miss S., who had been an overactive patient, attended a hospital dance. An experienced nurse thought the patient was showing signs of increasing excitement and, with the idea of observing and regulating the behavior, sat down beside her. They were chatting quietly when along came a student nurse who took the patient by the hand, drew her to her feet, and said, "This is a dance; don't sit down! Come, dance with me."

How could any nurse with little or no experience, or without knowledge of the particular patient, have understood those situations in full? How could any teacher have anticipated the particular behavior of the nurse? When you exercise the greatest care you may be unwise, but if you do not give your every word and action some thought, you may make a nursing error comparable to a break in sterile technique.

In handling immediate activities you should begin by formulating questions from your own general experience and especially from previous dealings with the particular patient. Then you should speculate on the significance of the behavior and on the probable subsequent behavior. On the basis of this speculation, you can make a decision regarding your own conduct. After you have acted on that decision it is important to evaluate what takes place.

A few situations, with questions that lead toward judgment for immediate management, follow:

A patient uses bad language.—Is this an isolated situation? Is it related to obvious irritation? Is it directed toward any one person? How offensive is it? Is it associated with malice? How much is the person responsible for what he says? Is he taking advantage of his position as a patient? Should he be curbed? Ignored? To what extent is the patient carrying social obligations?

A patient begins a harangue.—Will it be short? Long? Is there an obvious explanation? What is the motive back of it? Is there pressure of emotion? Is there an increase in volume and speed? Is there general excitement? Is the excitement increasing? Should the behavior be overlooked? Should something be done about it?

A patient makes a threat (this should be reported to the head nurse as soon as possible.)—Is the threat a single statement? Is there emotion back of it? Is it directed toward a particular person; if so, what is the relationship between the patient and the person mentioned? Is there deep and planned thought? Has the same threat been made before?

A patient shows increased activity.—Is the increased activity in speech? Motor? General? How do the eyes look? Is the voice raised? Louder? Is there an obvious explanation? Who was in contact with the patient immediately preceding? Should the patient be talked to? Read to? Left alone? Placed where there are less stimuli? Given something to distract him? Can the activity be directed into a constructive channel? Is it the beginning of increased general excitement?

This kind of study gives you insight into how to deal wisely in immediate situations—treat casually, ignore, compromise, retreat, seek advice, get help—and increases your sensitivity and speed in seeing cause-and-effect relationships.

Management at the moment is not the entire goal or the close of any situation.

For example, you may be going somewhere with a patient when she becomes upset over a dogfight. In a few minutes you may say, "If you are able to gather yourself together we shall go on," and the patient's reaction shows successful handling of the immediate situation. But the physician should know about the incident.

In another instance you may observe two patients dancing together too much and take one on as a partner. This solves the immediate problem, but the information should be reported.

When a patient evidently enjoys your company and one day says, "You remind me of my youngest sister," you may handle the situation well by saying, "Do I?" (which stops elaboration of the idea as it sends the patient's thoughts back to the statement already made) and passing the conversation on immediately to the atomic bomb or the local corn crop. The incident, however, is important.

Talk all these immediate activities over with the head nurse or instructor, for you have yet to learn what is significant in these everyday matters. By itself significant material has no distinguishing marks.

The third classification, *activities extending over a long period*, relates to those activities that modify moods and change attitudes of the patient. This is the heart of psychiatric nursing. Central problems are less technological than social in character, and nursing energy must be channeled into the disciplined observation of the patient's behavior.

Dissolving distrust is a nursing activity extending over a long period. Too often a patient admitted to a hospital for the mentally ill has been lied to in order to get him there without trouble. A distrust is established which has to be dissolved before effectual treatment can be begun. In this situation your tools are *your own integrity and your support of the things in which the patient has faith*.

It is acceptable to tell a patient that you will deal honestly with him, but that in itself will not gain the desired results. The fact has to be proved to his satisfaction. Be fair and honest. Always tell him just what you are going to do, and why, before you do it. In your own dealings with the patient never let him down in any way.

Knowing that it is easier for the patient to believe some things than others you can take a mental journey to discover where faith can be established more easily. Dissolution of distrust may begin through a sincere interest in a favorite grandchild, a pet dog, or a hobby such as photography.

Getting a patient who refuses food to want to eat is another nursing activity extending over a long period. You may not be able to persuade him to eat a particular meal, but after awhile and in most cases you should be able to bring about some change in the attitude toward food. To meet this particular nursing problem proceed in the following manner: Review reasons why patients do not eat, and investigate the particular reason for this patient's refusal. Speculate on indirect influences. Then formulate the exact problem as well as potential approaches, and analyze the total situation as to effort, negative results, and positive results.

For further details, see the discussion of nutrition on page 195.

Regarding activities extending over a long period, achievement cannot be charted as having taken place at a definite hour on a certain day. Fortunately, time is not fixed. The approach to the solution of these problems is subtle and demands imagination, enthusiasm, delicacy, and a penetrating mind. The method is continuous, with increased effort at favorable times. Success

lies largely in the realm of sensibilities—the spirit and attitude of the nurse, the mood and attitude of the patient at the moment, and a *favorable meeting of these two*. Reasoning and judgment are the means to success.

Nursing Needs.—The first nursing need is understanding. The nurse must understand human suffering—not just the pain of an ailing gall bladder, the hurt from a burn, or the agony of childbirth, but the suffering associated with human striving and frustration, with emotional immaturity, and with the dualism of life. Dualism includes discordant attitudes, opposed emotions, inconsistent thoughts, inharmonious thoughts and feeling states, antagonistic vital needs, incompatible beliefs and actualities, inner inertia and press for action, desire and conscience, ambition and defeat. The nurse must also understand quality in living, personality factors operative in illness, and positive patient-nurse relationships.

The second outstanding nursing need is knowledge of nursing skills and of the clinical aspects of mental illness. The material in this book deals almost wholly with the first of these two needs.

Success.—Immediate success is rarely evident. Effective activities are initiated largely within yourself and carried out often against the patient's resistive moods and attitudes.

If there is clearly a note of hope, if there is ground to appreciate that the particular behavior is a kind of interlude, or if you can see that you have an active part in bringing about improvement, an enthusiasm and interest can be whipped up quite easily even when the patient's behavior is disagreeable and wearing. These same behavior features without termination on the visible horizon and without immediate satisfactions present a much more difficult and afflictive personal problem.

Success is never assured or constant. A few successes seem to make a path along which others follow. Happily, success is not viewed in relation to a single situation, a specific hour, or even a particular patient, but measured in terms of a gradual gain over a long period. You fail only when you lose interest and stop thinking and trying. You cannot hope to be successful with all patients. Sometimes one person in the presence of another creates antagonisms that cannot be overcome. When this is so, probably the administration of successful care is impossible no matter how excellent a nurse you may be or how desirous and willing you are to assist the patient.

Compensation.—Effective care of patients with morbid thoughts and feeling states is not easy, particularly for the initiate, as experienced patients exploit inexperienced nurses. The student nurse needs aspiration and tenacity worthy of the traveler in "Excelsior." Definite goals, persistent thinking, and unceasing effort, however, make the horizon take on an aspect of the American Frontier—it keeps extending while more and more possibilities open up, fresh points of interest can be seen, new approaches loom into view, advanced methods are discovered. Your compensation is an inner satisfaction. Intellectual triumphs occur, but strengthening aid comes in the discovery of a moral tendency and a spiritual harmony.

The Patient as Teacher.—Regarding harmonious affective nurse-patient relationships, the patient himself is an outstanding teacher. Quite often he responds to stimuli so quickly and so vehemently that you see the effect of care and especially the consequences of your own general attitude and behavior. Thus he teaches you the importance of reciprocity in human relationships and the need for honesty in social relationships. You learn, in addition, that simple environmental situations can set off deep-seated emotional tension. Finally, you may discover that ordinarily you do not put sufficient effort into the prevention of unnecessary inconveniences or slight and cumulative irritations. The gravest lessons and the sharpest rebukes come from the patient.

Through contact with the patient you gain the experience that perfects study; knowledge acquired in the classroom merely places you in an intellectual relation with the subject matter. It is while dealing with the patient that you have flashes of insight into his point of view. You learn when to give in and when to stand firm; the importance of forethought, afterthought, objectives, right timing, slight changes in emphasis, fine distinctions, and finesse; and the need for simplicity, charity, and humility. In short, you discover details of procedure that make it possible to apply principles successfully.

The nurse-patient relationship is not unlike that in a general hospital; the needs, the methods, and the importance of a tension-free atmosphere, however, are more easily observed. Also, the forces responsible for unpolished, unpremeditated patient reactions are less difficult to recognize and analyze. An understanding of the problems that arise in the care of patients on psychiatric wards gives insight into the more prevalent but milder and less obvious

TABLE I

	General hospital	Psychiatric hospital
1. Hospitalization	Short stays	Longer stays
2. The Patient	<p>Is isolated A social problem A medical problem</p> <p>Is engaged for treatment and care</p> <p>Seeks physical comfort and medical care for his patient</p> <p>Behavior is of secondary importance</p> <p>Moods and attitudes are fixed</p> <p>Sensations are normal</p> <p>Intellect is intact</p> <p>Is willing to take care of himself</p> <p>Is oriented to the outside world</p>	<p>Is undifferentiated Loses his individuality Hospital life is adjusted to patient's needs</p> <p>Is indifferent and antagonistic toward treatment</p> <p>Seeks peace or an emotional, intellectual, and environmental equilibrium; physical pain is important but not frequent</p> <p>Behavior is of primary importance</p> <p>Moods and attitudes are fixed</p> <p>Negativeities are noticeably heightened</p> <p>Insight is frequently lacking</p> <p>Lives with other patients; social intercourse is important</p> <p>Sees no value in the outside world</p>
3. The Nurse	<p>Is concerned with the patient</p> <p>Is concerned with the family</p> <p>Is concerned with the social problems of the patient</p> <p>Is concerned with the physical problems of the patient</p> <p>Is concerned with the patient's requirements</p> <p>Much is accomplished alone</p>	<p>Is concerned with the patient</p> <p>Is concerned with the family</p> <p>Is concerned with the social problems of the patient</p> <p>Is concerned with the patient's requirements</p> <p>A large amount is accomplished with the help of others</p>

TABLE I (Continued)

	Care of the patient	Psychiatric hospital
Treatment	<p>Diagnosis in the context of the social and cultural environment</p> <p>Reaction to an illness of an individual family-related</p> <p>Physical and medical care of the patient</p> <p>Orientation to the hospital and its surroundings</p>	<p>Diagnosis in relative and absolute medical terms and treatment of diseases and symptoms</p> <p>Reactions to the patient's illness</p> <p>Nursing and care of the patient and his/her family in the hospital</p> <p>Physical and medical care of the patient and surroundings</p> <p>Orientation to the hospital and its surroundings</p>
Procedure	<p>Diagnosis and treatment of the patient in the context of his/her social and cultural environment</p> <p>Maintaining and developing the patient's self-care skills</p> <p>Encouraging the patient to express his/her feelings and thoughts</p> <p>Orientation to the hospital and its surroundings</p> <p>Physical and medical care of the patient</p> <p>Maintaining and developing the patient's self-care skills</p> <p>Orientation to the hospital and its surroundings</p> <p>Physical and medical care of the patient</p>	<p>The patient's behavior and reactions to the hospital environment and his/her social and cultural environment</p> <p>Maintaining and developing the patient's self-care skills</p> <p>Encouraging the patient to express his/her feelings and thoughts</p> <p>Orientation to the hospital and its surroundings</p> <p>Physical and medical care of the patient</p> <p>Maintaining and developing the patient's self-care skills</p> <p>Orientation to the hospital and its surroundings</p> <p>Physical and medical care of the patient</p>
Environment	<p>Diagnosis and treatment of the patient in the context of his/her social and cultural environment</p> <p>Maintaining and developing the patient's self-care skills</p> <p>Orientation to the hospital and its surroundings</p> <p>Physical and medical care of the patient</p>	<p>Diagnosis and treatment of the patient in the context of his/her social and cultural environment</p> <p>Maintaining and developing the patient's self-care skills</p> <p>Orientation to the hospital and its surroundings</p> <p>Physical and medical care of the patient</p>

* When the term "care of the patient" is used, it refers to the activities of the nurse which may be therapeutic and therapeutic-like.

TABLE 1 (*Continued*)

	General hospital	Psychiatric hospital
	Acute problems relate mostly to things—equipment, time, physical condition of patient Success is immediate, apparent, and on record (if a temperature sponge bath reduces fever 1 degree, this is observed within 30 minutes and recorded)	Acute problems relate mostly to people—sensitivities, the patient's faulty logic, patient-nurse relationships Success is delayed, not apparent at a given moment, not recorded as occurring at a specific time

emotional situations present in the care of patients in a general hospital. Apparently many of the problems dealing with a patient's emotional life must be met in the extreme and the exaggerated in order to be appreciated in the moderate and the normal.

Psychiatric Nursing Compared to General Nursing.—Psychiatric nursing is neither new nor vague. It is actually a further development and refinement of certain aspects of general nursing. Comparison brings out the similarity and the complementary factors.

General Aspects.—Psychiatric nursing care and general nursing care are identical in the following major points: (1) The central objective is ultimate comfort for the patient. (2) Treatment and care relate to the whole patient. (3) The field of operation is the patient and his environment.

Emphasis.—The details of nursing care are also similar; the emphasis, however, is different. Psychiatric nursing stresses (1) orientation of care around the patient as a person, (2) psychological (emotional, intellectual, volitional) and social aspects, and (3) the nurse as the principal factor in the environment. Other aspects are not given less consideration, but these are given special attention.

Detailed Items.—Many of the items in Table 1 show differences; however, the difference is not in nursing care but in shift in emphasis, made necessary by the points listed.

Complementary Aspects.—Before long we shall speak only of psychiatric aspects of nursing. General and psychiatric nursing are not separate forms of nursing education nor in competition with each other. The combination of their dominant aspects makes for completeness and perfection in each field.

General nursing activities, particularly nursing skills, are used heavily on the psychiatric wards, and psychiatric nursing problems are just as prevalent although less obvious in the general hospital. All in all, psychiatric nursing makes a recognizable contribution to general nursing, while general nursing provides not only a basis for psychiatric nursing but a medium in which its fullest potentialities can be developed.

OUTSTANDING NURSING OBJECTIVES

Nursing objectives are established goals for patient care. The following objectives are important:

- | | |
|---------------------|--|
| Specific | To carry out physicians' orders and ward routines. |
| Central | To make the patient ultimately more comfortable,
especially from an emotional point of view. |
| Initial | To gain rapport. |
| Principal | To modify moods and change attitudes. |
| General | To be a wholesome companion; to create a ward atmosphere
in which the physician can work to best advantage;
to study your own behavior in the presence of
the patient; to know the patient as a person. |

Specific Objective.—The specific nursing objective is *to carry out physicians' orders and ward routines*.

Physicians' orders consist chiefly of definite orders regarding specific treatment. For several years these orders related entirely to established procedures and special activities; the handling of interpersonal relationships was left to the nurse and to the teaching personnel. More and more, through verbal orders and conference periods, physicians are giving suggestions and advice to nurses on the general way in which to deal with the particular patient or problem.

Realizing that her influence on the patient is either positive or negative, the nurse welcomes guidance. Because of human factors, a neutral position is hardly possible; such a position would carry with it a quality of indifference which would soon degenerate into

cold callousness. Even when the physician wishes the nurse to be neutral, this procedure too must be directed.

The nurse's influence on the patient includes immediate environmental situations and indirect effects. The patient's chief complaint, or principal trouble, is not of primary interest to the nurse. In fact, she makes a sincere effort to avoid it and she seeks specific guidance in interpersonal relationships so that she will not be dragged into the midst of it before she is aware of what is happening.

Ward routines serve several purposes. In group life they meet the need of, and provide maximum comfort for, the majority. They also contribute toward habit training for the patient. Finally, they simplify nursing and make it technically more secure. However, ward routines—even a specific order—must sometimes be sacrificed for a sound individual need. Fortunately, the decision need not rest on the person with whom the question first arises. In the following situations, the individual need might have prevailed over the routine:

Mrs. G. asks to shave or be shaved because of a heavy growth of hair on the chin. She is told razor blades are not allowed in the women's wards.

Mrs. H. asks to talk with her physician. She is given the information that when the physician wants to talk with her he will come to see her or call for her.

Because of hay fever, Mrs. F. asks to remain on the ward while the others go outdoors. She is told she must go along.

Mrs. W. is scheduled to go to the operating room; she becomes panicky. She is told not to act like a child and to hurry up because the physicians are waiting. (The patient died in the operating room and those were almost the last words said to her.)

Because of high blood pressure Mrs. K. is brought to a hospital for the delivery of her twelfth baby. Previous to the delivery she becomes emotionally upset because she is not allowed to walk the floor.

In such situations, the first point—and the one that is too often overlooked—is to realize the existence of a legitimate question. A student nurse brings such matters to the head nurse and the head nurse to the supervisor; the supervisor gives advice, then

contacts the physician or has the head nurse do so. If the matter is not an emergency, the head nurse lets the matter stand until the physician makes his rounds.

Regarding physical health, a supervisor or head nurse recognizes a symptom before it becomes serious, but from an emotional point of view tremendous damage (without immediate evidence) can be done through ill-chosen words. Be very careful about the answer you give any patient and do not consider the problem finally settled in your own mind until you have talked the matter over with the head nurse. Periodically throughout the day report to the head nurse on conversations with patients.

Central Objective.—The objective toward which all others focus is *to make the patient ultimately more comfortable, especially from an emotional point of view.*

The outstanding discomforts of the person who is mentally ill are morbid thoughts and feeling states. The comfort sought involves inner strength, wholesome satisfactions, and peace through the resolution of inner tensions. The entire program of therapy and care is to this end.

For the most part, required activities are established through specific orders and ward routines, but *you* make these pleasant, interesting, alive. It is from your attitude that the patient senses their real value. In all nursing activities, management of the patient's immediate and ultimate emotional needs is a major detail in the practical problem of dealing with the patient in action. Conferences with the physician concerning this activity are helpful.

When we consider the patient's immediate emotional needs, disagreeable, offensive, and destructive properties of behavior come to the front, and it is particularly noticeable that so much of the behavior relates to unhappy feeling states. The patient may be sad, excited, indifferent, aggressive, jealous, dissatisfied, demanding, critical, hostile, indecisive, irritable, ready to take offense, provocative, or unreasonable. The patient may have lost faith, be filled with hatreds, uninterested in anything or anybody but himself. He feels inadequate, inferior, unappreciated, worthless, alone, unloved, frustrated, suspicious, afraid. He is in a state of desperation, and his behavior is an expression of an unsuccessful effort to find peace. He needs understanding and a tangible strength that is greater than his own. These points are beacon lights in nursing care, although in general your responsibility is to

supply friendliness, objectivity—with a conscientious, sincere interest—and to be a kind of balance wheel or buffer.

At heart the patient is a gentle soul. Your positive influence is in direct proportion to your capacity to generate and stimulate feelings of affection; however, you have an especially difficult task. It is difficult because the patient's particular feeling state, or rather its inflexible quality, obstructs affection and even promotes antagonism in you. This difficulty is increased by the fact that the patient's immediate emotional cravings often conflict with ultimate needs.

Since the entire care of the patient centers around ultimate comfort, an immediate emotional need is never met at the expense of an ultimate one. The lonely person is not constantly surrounded with company, the emotionally starved human being is not called "deary"; the middle-aged, emotionally immature individual is not addressed by the childish nickname. Loneliness, emotional hunger, immaturity are not supported by shallow means and fed with moments of temporary relief.

The final goal is fortitude and satisfaction through the development of potential capacities, competence in work, pride in work, and success, as well as through a balanced program of work, rest, and play, and increasing faith. To this end, all treatment and care propel the patient toward self-reliance and help him to direct psychic energy into constructive, satisfying channels.

Initial Objective.—The initial objective is *to gain rapport*. Rapport refers to a harmonious emotional relationship. It is more than establishing trust, confidence, and respect. It signifies a mutual understanding. You and the patient find something in common and respond to each other. With this relationship established you can do a great deal for the patient and the physician; without it, you can do nothing effectively.

Rapport takes a little time to create and build and depends on deep inner qualities—a sincere interest, dependability, integrity, understanding. Superficial attractions are not particularly helpful. The proper development of rapport determines the trend in patient-nurse relationships and affects the immediate subsequent course in patient behavior. Strength lies in diplomatic measures. For ideas on gaining rapport see Chap. III, "Remedial Approach."

Principal Objective.—The principal objective of psychiatric nursing is to modify moods and change attitudes, particularly

pathological moods and unwholesome attitudes. This is the very heart of psychiatric nursing, and a teaching and learning process is involved. Achievement depends on the management of interpersonal relationships, which includes applying knowledge, spirit, interest, objectivity, tenderness in intellectual action.

The intensive work of the nurse is on an external level as compared with that of the physician, who deals with the patient's chief complaint and deeper issues, with internal situations (inner tensions, conflicts, trends), with intelligence, and with the heart of character and personality. You deal with the patient's secondary complaints and superficial issues, with external situations (irritation over cold coffee), with sensibilities (transfer of feeling tones rather than an appeal to logic) at least in the beginning, and with the periphery of character and personality. In general, you work through indirect ways and means and with immediate and external matters.

Outstanding difficulties arise from these facts: (1) The pathological mood is fixed and rejects what is not congenial with it. (To thrust pleasure on a depressed patient is to push him further into depression; to restrain elation is to produce explosive behavior; to press a seclusive patient into activity is to meet open opposition.) (2) The responsibility for all positive advancement lies entirely with you. (3) Effective nursing duties cannot be prescribed in advance.

The modification of symptomatic behavior is a positive function. It is here that psychiatric nursing stands out as something apart from general nursing. However, the mind and the body are inseparable parts of a complete whole. Just as psychiatric nursing care includes general nursing aspects, so should general nursing care include psychiatric aspects.

GENERAL NURSING OBJECTIVES

The successful psychiatric nurse should be a wholesome companion to her patient, create a ward atmosphere in which the physician can work to best advantage, study her own behavior in the presence of the patient, and know the patient as a person.

Being a Wholesome Companion. Psychiatric nursing is carried out on a level of health and you serve as a pattern. It is up to you to create healthful situations.

Personal contact is the method used. Your actions serve as a model, your words as a guide. Your own cleanliness, physical fitness, healthy attitudes, equanimity, zest for living, culture, and the presentation of matters of pleasure, interest, substance put the patient in touch with health and with practices conducive to wholesome and successful living.

Ward Atmosphere.—The general atmosphere of the ward is an important part of effective care. A substantial, stable, friendly patient-personnel relationship is the atmosphere in which the physician can work to the best advantage. The nurses set the pervading influence. Atmosphere is infectious, contagious, electric.

Friendliness initiates warmth, kindness softens rough manners, generosity melts irritation, graciousness fosters agreement, just praise quickens joy, dependability provides strength, honesty promotes candor, fairness promises assurance, beauty arouses imagination, good humor contributes lightness, attention generates feelings of worth, activity awakens life, personal interest stimulates alertness and good feeling and is a source of inspiration and courage.

Through the behavior of the nursing personnel it is possible to make a patient feel calm, comfortable, secure and thereby change noise and uncontrolled activity to quiet and order (see discussion of transfer of feeling tones, page 32). The patient's confinement in a hospital ward should be the proper prelude to a state of peace and the atmosphere should be conducive to the development of interest, reassurance, vitality, serenity. Such an atmosphere is a calculated achievement.

The Nurse's Behavior.—Your behavior can modify the conduct of the patient. To study your own behavior in the presence of the patient is the initial step in learning how to modify moods and change attitudes (your own as well as those of the patient) whether normal, abnormal, or pathological.

More often than not, the need for modification of behavior is the reason for the patient's hospitalization. Modification is largely accomplished through interpersonal relationships. Your obligation is to manipulate environmental factors of which you yourself form the largest part. Everything you say to a patient or do for him, every move you make, your very presence exert an influence on his immediate condition. If this influence is to be for

good and is to be controlled, you are obliged to examine your own words and actions.

Aim of Study.—In a study of your own behavior the general aim is to awaken intelligence and idealism.

The possession of ideals will help you to create methods. Detailed steps in reaching this aim are the following:

Do nothing inconsiderately.

Have a purpose in everything you say or do.

Have exact ideas on effort expended.

Direct behavior toward social ends.

Regulate your own feeling states and maintain a lofty simplicity equally remote from emotional sentimentality and cool indifference.

You are not an animal trained to give a perfunctory performance; you are expected to discriminate, to evaluate, and to reason in regard to definite goals. You will be guided in the proper and expedient course by the physician (orders, suggestions, advice), the patient himself (looks, posture, turns and expression of body and limbs, tone of voice), self-development (the expansion of your own consciousness).

Personal development provides the basic background for all psychiatric aspects of nursing: You can understand and enter into the life of your patient only to the extent that your own world of perceived qualities and relationships will permit. Use spare time to discover new worlds. Whether you listen to a lecture or some good music, read a worth-while book, cultivate a hobby, enjoy a baseball game, fall in love—the more contacts you make the more alive you will be and the more able to understand the patient and provide what he needs.

Method of Study.—As a definite procedure for study, consider a particular time (9 A.M.), a specific nursing activity (giving a bath), and a special problem (getting a patient to take nourishment).

At the intended time or occasion pay attention to what takes place between the patient and yourself and, for your own use, record as soon as possible what the patient said and did, his mood and attitude, what you said and did, and your own thoughts and feeling state.

In the patient-nurse relationship all interest and exertion come from you. It is not enough to *think* you have done your best —

you must *know* exactly the different ways you have tried to influence the patient in a particular situation so that you can reflect upon them at leisure and recognize why you succeeded or failed. Usually it is not because your behavior is wrong or unwise, but because you have not thought of enough things to try; there has been a lack of energy and initiative in thought and action, a constriction in the field of approach.

Recording and studying your own behavior provides something on which to ponder, and it may help you to improve. At first you will find it difficult to see yourself truly in patient-nurse situations, but your attitude will change and your capacity will increase when you realize that you are merely developing a framework on which to build nursing care.

The idea of paying attention to one's own behavior for managing interpersonal relationships is an old one. In "Pilgrim's Progress" we find, "I did as other considerate persons do, I looked out if perhaps I might mend myself."

Likewise, Walter Pater's Marius the Epicurean and Pierre Bezuhhev in Tolstoy's "War and Peace" recorded their own actions. Socrates' injunction, "Know thyself," is fundamental. You must know yourself in relation to your patient.

Effort.—In studying your own behavior notice where the bulk of your thoughts lie; thinking should center on effort. The ultimate aim or driving power receives the emphasis. Certainly from a psychiatric-nursing point of view the fact that a patient does not take nourishment is less important than what you do to change and shape his attitude toward the need. Also, failure in any single situation is so frequent that if you depend on satisfaction from attainment only you will be left in a state of frustration with self-confidence destroyed.

Supposing a patient is ordered "extra nourishment daily." In a general hospital more than likely the patient will take the nourishment, but, if he does not, he is responsible for his acts and it is permissible to record the treatment "refused" and consider the duty ended. On a psychiatric ward the situation is different. When the patient refuses the nourishment the truly psychiatric aspect of care (what is done to change the patient's thoughts and feeling state) begins, especially at the point of contact between the patient and the need. This may take several weeks.

Always the final achievement comes from your own mental toil.

Most of the time you must labor more on yourself than on the patient, and until you grasp a shift in your way of thinking you are on unfamiliar ground.

In endeavoring to meet a specific need, search diligently and constantly for ways of motivating the patient, formulate objectives, weigh superficial and basic aspects, review information relating to the problem at hand, think in terms of the patient's past and of the impressions you wish to make. Sow intellectual and emotional seeds and nurture these with spirit, strength, generosity, wisdom. Be alert to every response. Think, appraise, reject, plan, aspire. Intellectual effort is a nursing necessity, and satisfaction must be experienced in effort expended.

Feeling Tones.—In examining your own behavior, be especially interested in the way you influence and regulate the feeling tones of your patient.

Feelings are body states of pleasantness or unpleasantness. With the person who is mentally ill the feeling states are predominantly unpleasant. In dealing with the patient, meditate on the proportion of pleasant and unpleasant feeling states and behave in keeping with the occasion and the need. One does not cry at a carnival or laugh at a funeral. These particular occasions are not encountered on the ward; the concept, however, is applicable in rare and delicate situations and in infinitesimal detail.

A story is told of a group of visitors viewing the Sphinx. One woman was so overcome with emotion that she sat down; immediately another member of the party tapped her on the shoulder and said, "I know just how you feel; my feet hurt, too." Before you can accept responsibility in regulating the feeling state of a patient you must be able to recognize accurately this state at any given moment.

Most nurses can recognize grief, physical pain, happiness, love; and no skill is required in sensing that the patient is mad as a hornet. But you must expand and refine your power of perception to observe minute distinctions in inner feelings and to acquire skill in this direction. Lacking psychiatric experience, nurses confuse resignation for repose or report a patient as "not sleeping but not suffering" when he is emotionally distressed by deep inner wounds or fairly crushed by conflict.

Indices of feeling states are found in physical signs. Some of the desired knowledge can be stated grossly, e.g., in repose the shoulder

seems a part of the body but at other times it appears as a part of the moving arm. The knowledge that will have meaning to you comes from your own observation and conclusions. When a patient perspires, yawns, blushes, cries, turns pale, is restless, you should wonder why and endeavor to find out. Study the significance of a glance, an accent, tension in the voice, knotted muscles, strained sinews, swollen veins (especially in the neck), wrinkles, compression and condition of the lips, pose and movement of the body, life and gestures of the arms and hands, projection of the chest, muscular movements of the shoulders, twist of the feet, set of the jaw, expression in the eyes, curve of the spine, movements of the fingers, every change of countenance. Also, study individual differences, *e.g.*, for some patients the eyes tell most about feeling states; for others, the hands.

With training in sharper observation, appraisal grows more penetrating, *e.g.*, by noting exaggerated mannerisms and subtle hesitations it is possible to determine when boldness merely covers up feelings of inferiority. Without seeing the patient's face, the efficient nurse understands the emotional significance of outlines produced by the hand or assumed by the body and accurately estimates moods and attitudes by body movements.

Regarding feeling tones, it is important not only to recognize and evaluate drifts of feeling in the patient but to realize how your own behavior transfers feeling tones to the patient and can bring about desired feeling tones in the patient. For short periods and on an external plane you can make a frightened patient feel calm, a sullen patient sweet, and, now and then, an unhappy patient can be made to feel as though he had a flower in his button-hole.

It is especially important to help the patient feel that he is accepted and welcome, that he belongs and shares, and above everything else that he is with those who have an appreciation of his problems and a genuine interest in his welfare. As previously mentioned, the general ward atmosphere holds a weighty place in the transfer of feeling tones.

Maintaining an Intellectual Distance.—In studying your own behavior make sure that you are keeping an intellectual distance. To maintain the desired friendly objectivity is not easy. A simple test is to answer the question "Am I equally patient with all patients?"

The difficulty is to weigh situations in relation to the need. If you like the patient, it is easy to make excuses for his behavior, saying that he needs only more time, he did not mean to, and so on. Frequently it is hard to be natural, as the patient's behavior prompts you to talk up or talk down, feel close or far away.

Practical problems are mostly concerned with emotions and feeling states, but reason and judgment are the means of mastery. You cannot influence a patient unless you are sensitive to his influence; sensitivity, however, refers in this instance to dealing with the matter, not to absorbing the feeling state of the patient. You do not share his worries or problems. You do not feel his discomfort. You experience an awareness of it and, within yourself, you consult reason and explore your thoughts concerning the possible solution of the problem.

Result of Study.—Through a study of your own behavior in the presence of the patient, you should, first, see how important you are in the patient's environment. (Nurses make up the more or less constant environment of the patient.) Then you should observe whether or not you are exerting a neutral, noninterfering interest. Learn to recognize nonessentials and notice how unimportant beginnings and piecemeal details come together to form a whole. You should appreciate that incidents of value are often of a volatile and evanescent kind. Think in terms of the realities of the problem and at the same time realize the necessity of thought and vision that extend beyond the day's obligations. You should be able to crystallize valuable ideas, cumulate judgments, and establish a store of useful experience in handling interpersonal relationships, all of which means that you will be better equipped to redirect effort intelligently.

The patient-nurse relationship cannot be satisfactory always. You may have personal characteristics that a patient dislikes, and very often you cannot remove unpleasantness for the patient. By examining your own behavior, however, you will realize when you distress him. The study of your own behavior keeps you from

Exhibiting fire when he needs quiet.

Introducing gaiety when he is meeting a life crisis.

Crushing his feelings when he longs for personal freedom.

Talking when he wants solitude.

Crossing unknowingly some small ambition which he values greatly.

Defeating some desire for praise which he cannot patiently suffer to have frustrated.

Shattering his self-control through small mischances.

Adding so much as a transient sigh to the great total of his unhappiness.

If you do *not* study your own behavior in the presence of the patient, the problem of nursing care is not merely unsolved but unattacked.

The Patient as a Person.—This is an essential objective in the care of those who are mentally ill. The aim is to obtain a photographic conception of the patient, his outstanding life experiences, and his way of living. The study is personal but more or less superficial.

The source of information is daily contact with the patient. Be alert for important items. Do not attempt to probe into the patient's heart or dissect his soul, and above all you should appreciate that an intensive study of sordid details in the social history is not necessary for immediate needs.

How much should you try to learn about the patient? Enough to understand him but not enough to allow him to fear you. You need only general ideas, life crises, external items. For example, it is helpful to know that the patient was brought up by a sadistic aunt, lost all his money, was jilted by his fiancée, and it is useful to know that he likes baseball and *The Saturday Evening Post*. He will tell you these things himself.

The patient will want to give you more information than you need and, perhaps, than you should have. Be careful. Too much information, especially about unhappy aspects of his life, can destroy the desired relationship. Today he may want to unburden his heart, but tomorrow he may be sorry. If you know too much about him, he may be afraid that you will laugh at him—vital human needs and reactions to them cannot be expressed adequately in words. He may fear that you will think less of him or that you will tell someone else. Since he cannot be sure, he will be testing you in all kinds of ways. If he is unhappy about the matter, he will not be angry at himself for having told you but annoyed at you for having listened.

In all your dealings with the patient, keep away from the chief complaint. When the patient begins to give detailed personal

information you may have to say, "It is better that you do not tell me, but Dr. [naming his physician] should know this." Then introduce another topic, not so abruptly as to be rude but soon enough to change his line of thinking and make the situation final. You do not have help to offer the patient on his deep inner problem, and if he relieves the emotional tension in talking with you he may not have so great a need to talk with the physician.

The purpose in knowing the patient as a person is to understand him, to see situations from his point of view, and to use this understanding as a basis for nursing care. This care, when based on a knowledge of the patient as a person, should aim to

Meet the patient on his own plane of understanding.

Adjust the environment to his capacity and understanding.

Develop attitudes that respect the patient's individuality.

Establish principles of justice and fair dealing; promote reciprocal relationships.

Find an interest that can be utilized.

Add a personal touch to nursing care.

Use the past as information on how to deal with the present.

Predict behavior reactions.

The outline for a study of the patient as a person, including observation and care, is shown in the following sample study:

THE PATIENT AS A PERSON, OBSERVATION AND CARE

Ward.....	WI
Initials ¹	L. S.
Date observation begins ²	Jan. 1, 1945
Age.....	Seventeen
Height.....	5 ft. 3 in.
Weight.....	80 lbs.
Marital status.....	Single
Children, names and ages.....	None
General appearance and behavior	Neat, careful about detail, sulky, industrious at times
Religion.....	Protestant
Education.....	10th grade
Occupation.....	None

¹ Omit name, material is too personal to risk identification.

² Observation is continual.

Physical condition.....	Fair, underweight, pimples over face and body
Physical defects.....	None
Hygienic habits.....	Bathes regularly; irregular about bowel evacuation; eats only what she likes; wants to stay up late at night and remain in bed in the morning
Sleep.....	Averages about 6 hours a night; sleeps best toward morning; sleeps without a pillow
Recreation.....	Rarely plays; reads in spare time
Habits.....	Uses rouge too freely; begins every sentence with "well"
Interests.....	Books; boats; matters relating to nature
Hobbies.....	None
Ambition.....	Wants to be a stenographer
Likes.....	Arithmetic; birds; peppermint candy; waffles; books, book review section of the Sunday edition, <i>New York Times</i>
Dislikes.....	Color red; cauliflower, turnips, in fact, most vegetables; a seersucker dress her aunt gave her
Special aptitudes.....	Coordination good; thinks quickly; all movements fast, sure, conservative
Personal assets.....	Clean and neat; sound teeth; beautiful hair
Personal liabilities.....	Unpleasant disposition; unpredictable behavior
Sociability.....	Tends to stay by herself
Trends in conversation.....	Books; birds
Emotional tendencies.....	Suspicious; easily irritated
Worries.....	Pimples; loneliness
Immediate relatives.....	Aunt
Emotional tone toward individual relatives.....	Dislikes aunt
Most frequent visitors.....	None
Emotional reaction to visitors.....	
Insight into present illness.....	Appreciates she is not at ease with people or in handling her everyday problems
Medical history.....	Nothing significant
Social history.....	Parents died when patient was very young; she was brought up by an uninterested aunt

Specific Nursing Problems.

How to deal with the annoying behavior of mussing clothes in other patients' lockers and taking bites out of fruit belonging to other patients.

Approach to the Problem with Results.

Method of Approach (in consultation with physician)	Result
Teaching correct social habits.....	Negative
Making rules.....	Negative
Persuading.....	Negative
Intimidating.....	Negative
Scolding.....	Negative
Ignoring.....	Negative
Punishing (taking away privileges).....	Negative
Coercing.....	Defiance
Reducing attention to asocial behavior.....	Evidence of cooperation
Praising and rewarding social behavior.....	Evidence of cooperation
Stressing fairness and kindliness.....	Evidence of cooperation

Conclusion.

At least part of the cause of the patient's annoying behavior is insecurity, especially from a lack of affection and fairness in others. This agrees with a significant point in social history (brought up by an uninterested aunt).

Specific Points in Nursing Care.

The patient's specific need is for a sense of security. The procedure, therefore, is to provide security

1. By supplying affection and fairness.
 - a. Show kind feelings and personal interest. Pay attention to your own attitude, especially at times when the particular problem is not an issue; this is the time to make the greatest headway, because it is easier for both patient and worker to get nearer to each other and see the same point of view (understanding). Apply understanding, especially at times of definite disappointment (patient was about to finish making a sweater but found a mistake which necessitated ripping out much of the work). Make a point of knowing items of special interest to her and incorporate these in the conversation.
 - b. Increase patient's sense of usefulness and successful place in relation to others. Ask for opinion where her judgment is acceptable, particularly in relation to personal affairs—which dress she wants to wear. Give her minor ward responsibilities —general tidiness of linen room, sun porch. Create a feeling of partnership by using "us," "our," "we," as much as possible. Place her in group activities so that she meets with some successes.
 - c. Help others to see patient's positive qualities. Bring admirable qualities to the fore thereby arousing interest in, and affection for, her.

- d. Place patient near those who feel kindly toward her. Seat her in the dining room next to the person who has the greatest feeling of warmth for her (lonely).
- 2. By providing incentives at patient's level of appreciation.
 - a. Give her responsibility of daily care of the ward canary (likes birds).
 - b. Have her prepare a book review (likes books and the book review section of the Sunday edition, *New York Times*).
- 3. By stressing hygienic measures for improving condition of skin (worries over pimples).
 - a. Pay special attention to diet, elimination, exercise, fresh air.

Progress notes.

Jan. 1, 1945.....	Problem at its height. Patient-nurse relationship, not wholly satisfactory.
	Patient-patient relationships, unsatisfactory.
Feb. 1, 1945.....	Problem reduced. Patient-nurse relationship, improved.
	Patient-patient relationship, improved.
Mar. 1, 1945.....	Problem further reduced. Patient-nurse relationship, satisfactory.
	Patient-patient relationship, improving.
Apr. 1, 1945.....	Problem removed. Patient-patient relationship, satisfactory.
	Tractable; eager to learn about herself and her difficulties; accepts instruction regarding healthful living; condition of skin has improved for which she is very happy; patient is a positive factor in the general ward situation.

Result of Study.

By knowing the patient as a person, you

1. See relationships between his thoughts and feeling states and his behavior.
2. Recognize how a detail relates to the whole person—the tail of a cat cannot have meaning without knowing what a cat looks like.
3. Find material that presents a line of action for individualized care.

Psychiatric nursing is a very personal service. A broken leg may be nursed successfully without the nurse's knowing much about the patient's loves and hates; but the care of a person with morbid thoughts and feeling states requires knowledge on the patient's way of life. You cannot expect to deal successfully with a person in sickness or in health until you know something about him. As an example of this principle, it is only when we have

information on their own lives that we appreciate the reasons for Swift's contempt for humanity, Thackeray's general pessimism, and Heine's sorrow and bitterness.

Having to know the patient as a person makes it impossible ever again to think of him as Room 12, Bed 8, or Submucous Resection. The uninteresting or unpleasant patient, the nuisance, and the psychoneurotics are all seen from a different point of view.

REFERENCES

BOOKS¹

- DIEHL, HAROLD S.: "Healthful Living," 2nd ed., McGraw-Hill Book Company, Inc., New York, 1941.
- FOSDICK, HARRY E.: "On Being a Real Person," Harper & Brothers, New York, 1943.
- KLEIN, D. B.: "Mental Hygiene: The Psychology of Personal Adjustment," Henry Holt and Company, New York, 1944.
- KRAINES, S. H. and E. S. THETFORD: "Managing Your Mind: You Can Change Human Nature," The Macmillan Company, New York, 1943.
- MEREDITH, F. L.: "Hygiene," The Blakiston Company, Philadelphia, reprinted 1945.
- MOORE, DOM THOMAS V.: "Personal Mental Hygiene," Grune & Stratton, New York, 1944.
- MORLAN, GEORGE K.: "How to Influence Yourself," Berkshire Press, East Chatham, N. Y., 1944.
- OSLER, WILLIAM: "A Way of Life," Norman Remington, Baltimore, 1922.
- PRESTON, GEORGE H.: "The Substance of Mental Health," Farrar & Rinehart, Inc., New York, 1943.
- ROBINSON, G. CANBY: "The Patient as a Person," Commonwealth Fund, New York, 1939.
- STEWART, ISABEL: "The Education of Nurses," The Macmillan Company, New York, 1943.
- TURNER, C. E. and E. McHOSE: "Effective Living," 2nd ed., The C. V. Mosby Company, St. Louis, 1945.

ARTICLES

- ANDERSON, ESTHER. "Open Road Ahead in Psychiatric Nursing," *The American Journal of Nursing*, October 1941, pp. 1183-1188.
- BENNETT, A. E. "Modern Psychiatric Nursing," *The American Journal of Nursing*, April 1939, pp. 395-400.
- BIDDLE, W. EARL. "Psychiatric Affiliation and the Community," *The American Journal of Nursing*, November 1943, pp. 1032-1034.
- BILLINGS, EDWARD G. "Value of Psychiatry to the General Hospital," *Hospitals*, August 1941, pp. 30-34.

¹ See list of textbooks for nurses on page 163.

- BOYD, DAVID, JR. "Mental Hygiene Problems of Student Nurses," *Mental Hygiene*, April 1943, pp. 198-221.
- CHARTERS, W. W. "Personality in Nursing," *The American Journal of Nursing*, October 1930, pp. 1242-1246.
- DUERKSEN, TINA. "A Psychiatric Viewpoint," *The American Journal of Nursing*, November 1941, pp. 1277-1280.
- EWALT, J. R. "Psychiatric Preparation of Surgical Patient," *The Modern Hospital*, August 1939, pp. 62-63.
- FITZPATRICK, CHARLES. "A Psychiatrist's Views on 'Guidance' of the Student Nurse," *The American Journal of Nursing*, June 1944, pp. 588-590.
- FITZSIMMONS, LAURA W. "A Searchlight on Psychiatric Nursing," *The Modern Hospital*, May 1945, pp. 59-61.
- FITZSIMMONS, LAURA W. "Facts and Trends in Psychiatric Nursing," *The American Journal of Nursing*, August 1944, pp. 732-735.
- GARRISON, K. C. "The Use of Psychological Tests in the Selection of Student Nurses," *The Journal of Applied Psychology*, August 1939, pp. 461-472.
- HACKER, F. J. "The Concept of Normality and Its Practical Significance," *The American Journal of Orthopsychiatry*, January 1945, pp. 47-64.
- HAMILTON, SAMUEL and GROVER KEMPF. "Trends in the Activities of Mental Hospitals," *The American Journal of Psychiatry*, November 1939, pp. 551-562.
- HAMILTON, SAMUEL. "Life in Our Mental Hospitals—Its Meaning for the Individual," *Mental Hygiene*, January 1943, pp. 4-9.
- HUTTON, E. L. "What Is Meant by Personality?" *The Journal of Mental Science*, April 1945, pp. 153-165.
- JOHNSON, F. ERNEST. "Character Education," *The American Journal of Nursing*, July 1940, pp. 761-766.
- KEYES, B. L. and R. MATTHEWS. "Psychiatry in a General Hospital," *The American Journal of Psychiatry*, March 1942, pp. 1272-1287.
- LEWIS, NOLAN. "Perspectives on the Mental Hygiene of Tomorrow," *Mental Hygiene*, January 1944, pp. 15-22.
- MCLEOD, W. MALCOLM. "General Hospital Care for Nervous Patients," *The Modern Hospital*, November 1938, pp. 66-67.
- MARTIN, G. G. "Mental Hygiene in a General Hospital," *Mental Hygiene*, April 1939, pp. 190-195.
- MATHER, VERA G. "The Psychiatric Aspects of General Nursing," *The American Journal of Nursing*, November 1937, pp. 1187-1196.
- MENNINGER, KARL. "The Future of Psychiatric Care in Hospitals," *The Modern Hospital*, May 1945, pp. 43-45.
- MENNINGER, WILLIAM C. "Psychiatry in Nursing Education," National League of Nursing Education, 44th Annual Report, 1938, p. 201.
- MEYER, ADOLF. "Dealing with Mental Diseases," *The Modern Hospital*, September 1938, pp. 87-89.
- MUNSON, BARBARA. "Pediatric Nurses Need Psychiatric Training," *The American Journal of Nursing*, January 1945, pp. 50-53.
- OETTINGER, KATHARINE BROWNELL. "Toward Inner Freedom," *The American Journal of Nursing*, November 1939, pp. 1224-1229.

- OETTINGER, KATHARINE BROWNELL. "Mental Hygiene and the Nurse," *The American Journal of Nursing*, December 1943, pp. 1091-1094.
- PATERSON, JEAN MACDONALD. "Psychiatry's Claim to Priority in Nursing Education," *The American Journal of Nursing*, September 1943, pp. 843-845.
- PATTON, EDITH. "Psychiatric Nursing in the General Hospital," *The American Journal of Nursing*, March 1945, pp. 193-195.
- PLANT, JAMES. "Today's Responsibilities in Mental Hygiene," *Mental Hygiene*, January 1944, pp. 10-14.
- SAUNDERS, ELEANORA. "The Person Sick," *The American Journal of Nursing*, December 1931, pp. 1377-1380.
- STEVENSON, GEORGE H. "Ward Personnel in Mental Hospitals," *The American Journal of Psychiatry*, January 1935, pp. 791-798.
- STEVENSON, GEORGE S. "Mental Hygiene Problems of Youth Today," *Mental Hygiene*, October 1941, pp. 539-551.
- WALKER, KENNETH. "The Need of a Positive Philosophy of Life," *Mental Health* (London), October 1941, pp. 102-108.

CHAPTER II

BEHAVIOR: OBSERVING, RECORDING, UNDERSTANDING, MODIFYING

BEHAVIOR

Meaning.—The term “behavior” refers to all human activity, all responses of the organism, both inside and out; thoughts and feeling states are behavior just as much as temper tantrums.

Pathological (Symptomatic) Behavior.—Symptomatic behavior refers to reactions that are inadequate or inappropriate, unadaptive, and incapacitating. These reactions are the symptoms of illness. Psychiatric nursing centers around behavior.

At this point it is well to review a few pertinent items regarding the function of the nervous system in general and the brain in particular.

The nervous system, consisting of the brain, spinal cord, and nerves, is the great master system of the body. Briefly, its function is to integrate mechanisms within the body and to integrate the activities of the individual to the requirements of the environment. In mental illness the conspicuous symptoms appear in relation to the second function.

The brain resides in the cranial cavity and is the anatomic correlate of mind. The cortex of the brain, the gray matter situated on the surface, is the essential or functional part. This is concerned with (1) sensorium, having to do with perception (awareness of objects, feelings); (2) intellect, having to do with thinking (seeing relationships); and (3) motorium, having to do with volition (purposeful activity).

Idea and purpose are initiated in the cortex of the brain; the detail and the mechanics of willful movements are integrated and carried out to the best effect by the midbrain and spinal cord. As an organ, the brain's special function is to deal with the environment, and in mental illness the individual's adjustment to his environment is unsuccessful.

Nursing Responsibility.—Regarding the patient's behavior, your responsibilities are to *observe*, to *record* to *understand*, and to *modify*.

OBSERVING BEHAVIOR

Principal Objective.—In observing behavior the principal objective is to *look for signs that tell how the patient reacts to life situations on the ward*. These signs relate to the patient's relationship with people—nurses, attendants, other workers, and patients; his reactions to ward routines and treatment; his use and management of energy; and his intellectual and emotional adequacy.

Important Points.—In the observation of the patient's behavior it is important to appreciate that *you are not looking for symptoms of a specific illness*. In describing the patient's behavior *psychiatric terminology is not necessary*. It is important to realize that *objective behavior*—what the patient says and does—provides the source material for hospital records and that any change in overt behavior or any unusual behavior is significant material. *Subjective behavior*—what the patient thinks and feels—provides the key to understanding.

Approaching the observation of a patient's behavior with a preconceived idea of a specific illness conditions you to find signs of that particular illness. The observation's usefulness to the physician is lost. Watch particularly for changes in behavior. These are significant of shifts in thoughts and feeling states and are important in estimating the patient's condition and subsequent behavior.

Purpose.—Regarding the observation of behavior, the purpose is to *report and record objective behavior aspects* and to *recognize subjective behavior aspects*.

Reports and records are always concerned with objective behavior aspects, specifically, what the patient says and what the patient does. Such information helps the physician to appreciate the level of health (illness) and to determine therapeutic needs.

Recognizing subjective behavior aspects, a much more speculative activity, is of value purely for your own development and use. It helps you to appreciate the patient's inner emotional state at the moment, to understand what you observe, and to predict subsequent behavior. It also is a valuable aid in determining immediate working plans.

Difficulties.—The observation of behavior presents certain difficulties; these relate to the *newness of the experience*, to *ingrained misconceptions*, and to *characteristics of symptoms*.

To look for symptoms in behavior is a new experience, and it takes some time to learn what constitutes significant material.

The inexperienced nurse often comes to the field of psychiatry with misconceptions regarding the patients' behavior that are in line with popular beliefs. Before you can proceed with an open mind to study the behavior of those who are mentally ill and perform duties in an active, progressive way, you may have to discard some common but incorrect ideas. To offset these common misconceptions, the following should be kept in mind:

1. The symptoms of mental illness do not relate wholly to conduct.
2. The symptoms of mental illness are not always obvious; behavior may be perfect if judged by social standards; reasoning and judgment are not always impaired.
3. "Insanity," a legal term, refers only to a small group of mental illnesses—those in which there is a full-blown psychosis.
4. The patient probably comprehends what goes on around him; he has normal sensibilities; if anything, sensitivity is increased. There is a natural tendency to look upon the difficulty in the field of interpretation as faulty perception.
5. Few patients are dangerous to others; many are dangerous to themselves. The patient is interested primarily in himself. This explains why patients do not plan and organize concerted activity for escape, mischief, misdeeds, and why inebriates and drug addicts are so much harder to nurse.

With patients who suffer primarily with a physical illness the cardinal symptoms relate to temperature, pulse, and respiration. The symptoms are usually complained of by the patient; they are easily recognized and subject to verification.

With people who are mentally ill the cardinal symptoms relate to behavior. These symptoms are frequently not recognized by the patient. They are not always evident and are sometimes transient. They are elusive in quality because of their *subjective aspects*, often masked and purposely concealed.

Because of these characteristics, accurate observation and recording of behavior are not a simple matter but a great challenge.

Outline for Observation.—The following outline presents a method for investigation.

1. General appearance and behavior
2. Stream of talk
3. Mood (affect)
4. Projections
 - a. Delusions
 - b. Hallucinations
 - c. Ideas of reference
 - d. Ideas of influence
 - e. Ideas of persecution
 - f. Fears, phobias, obsessions, compulsions
5. Sensorium and intellectual reactions
 - a. Orientation
 - b. Attention
 - c. Memory: past, present
 - d. Calculation and general information
 - e. Reasoning and judgment
 - f. Insight

Such an outline is used by physicians for the mental examination of the patient. For you the outline is merely to establish an orderly approach and to provide definite focal points for directing effort in the observation of behavior. Your responsibilities demand special attention to the observation of objective aspects of behavior: general appearance, specific actions, stream of talk. An emphasis on behavior is a new approach in the search for symptoms; however, keep in mind that the recognition of changes in temperature, pulse, respiration, and an appreciation of the importance of pain, nausea, vomiting, etc., are as important on the psychiatric ward as on the medical and surgical ward. The following comments explain what is meant by the terms used in the outline and suggest how observations are to be recorded in accordance with the outline.

General Appearance and Behavior.—The observation required here relates to general appearance and spontaneous overt behavior: facial expression; posture; gestures; grimacing; condition of clothes, hair, nails; interest in appearance; reaction to others—physicians, nurses, attendants; table etiquette; overactivity or

underactivity; unusual activity; destructiveness; bizarre attitudes; management of hands.

Useful words for describing general appearance and behavior are listed below. (If a word has a definite meaning in the psychiatric ward, that meaning is given. For example, in the dictionary "untidy" means not tidy or neat; on the psychiatric ward the word is used to indicate that the patient is careless in regard to excreta and expectoration.)

active. Opposed to passive; being in action; energetic; busy.

afraid. Fearful; frightened.

aggressive. Pushing; invasive.

agitated. Put in motion, shown by biting nails, pulling at hair, pacing floor, wringing hands.

aloof. Apart; at a distance but within view.

antagonistic. Opposing; hostile.

anxious. Frightened; concerned over impending danger.

apathetic. Without feeling or emotion.

apprehensive. Fearful.

bellicose. Inclined to fight.

belligerent. Hostile; warlike.

boastful. Given to, or full of, boasting.

boisterous. Acting with noisy turbulence.

brooding. Thinks anxiously on one subject (unpleasant aspect).

calm. Composed; at ease.

capricious. Fanciful; whimsical; changeable.

cheerful. In good spirits.

combative. Disposed to oppose by force; actually striking with a purpose of hurting.

cooperative. Uses effort toward same end.

dancing. Moving about nimbly, merrily, rhythmically.

decorating. Adorning (self) with flowers, bows, beads.

defiant. Showing contempt of opposition; declaring hostility.

destructive. Causing destruction; actually destroying goods or furnishings.

dictatorial. Autoocratic; tendency to make unreasonable demands; compels attention.

disdainful. Scornful; contemptuous.

disgruntled. Dissatisfied; in bad humor.

disinterested. Revealing a lack of interest.

disrobing. Undressing.

distractible. Easily distracted in regard to changing a line of thought.

dogmatic. Unduly positive in expressing opinion.

domineering. Tyrannical; overbearing.

drooling. Driveling; letting spittle drop from mouth.

ecstatic. In a state of ecstasy or rapture.

egocentric. Self-centered.

egotistical. Showing self-conceit with selfishness; self-exaltation; self-praise.

erotic. Pertaining to sexual love.

expectorating. Spitting.

exposed. Intentional exposure of genitalia.

exultant. Elated, outward expression of triumph or joy.

facetious. Witty; given to pleasantry or to somewhat unseemly jesting.

fretful. Complaining; impatient.

friendly. Amicable; sociable; warm-hearted.

frowning. Scowling; wrinkling of the brow; an expression of displeasure.

gesture. Bodily movements used as a form of expression.

gloomy. Downcast; morose.

grimacing. Distorting the face.

haughty. Contemptuously proud, especially arising from pride of birth or station.

hoarding. Collecting and hiding articles.

imitating. Mimicking (copying).

impulsive. Acting with sudden force; rash, sudden, unpremeditated activity.

inaccessible. The observer is unable to determine the person's thoughts.

indecisive. Uncertain; irresolute; extreme form is called aboulia.

indifferent. Unconcerned; unresponsive.

industrious. Diligent; busy; marked by intelligent work, self-directed.

inert. Lacking in active properties.

interested. Having an interest or concern; attentive.

irascible. Prone to anger.

irritable. Ill-humored; easily angered.

jocose. Given to jokes and jesting.

languid. Without force; weak; faint.

lethargic. Sleepy; dull.

listless. Spiritless; indifferent.

meddlesome. Officially intrusive; apt to interpose in the affairs of others.

mischiefous. Troublesome; annoying—implies sportive malice.

morose. Of a sour or gloomy temper; sullen; ill-humored.

noisy. Making noise.

nude. Naked.

panicky. Extremely fearful with physical signs of tremor, dilated pupils, or sweating.

peevish. Habitually fretful or complaining.

petulant. Capriciously fretful; peevish; impatient.

phlegmatic. Like phlegm; cold and sluggish.

playful. Full of play; merry; sportive.

preoccupied. Lost in thought; engrossed; absorbed in thought.

pugnacious. Belligerent.

quarrelsome. Disposed to quarrel, suggests pettiness or ill nature.

quiet. Not excited or anxious.

resentful. Full of indignant displeasure.

resistant. Showing actual physical resistance toward required activity.

restless. Uneasy; characterized by unrest; fidgety.

scolding. Reproof; rebuke.

seclusive. Tendency to withdraw or be apart from others.

self-mutilating. Inflicting serious self-injury.

singing. Vocal sounds uttered with musical inflections or melodious modulations.

sluggish. Hard to arouse and slow in motion.

sociable. Affable; communicative.

stealing. Taking without right.

suggestible. Easily accepts suggestions especially in regard to a change of thought, feeling tone, or action.

suicidal. Actual attempt to take own life; expression of desire to take own life.

suspicious. Mistrustful; doubtful.

tactless. Lacking in sympathetic perception especially of what is fit, considerate, or gracious.

terrified. Greatly frightened.

threatening. Uttering threats.

tidy. Orderly; neat.

timid. Faint-hearted; retiring; shy.

touchy. Ready to take offense.

unkempt. Disheveled; tousled; ruffled.

untidy. Careless in regard to excreta and expectoration.

weeping. Shedding tears.

yelling. Shrieking; shouting; uttering loud, sharp noises.

Stream of Talk.—This heading suggests observations having to do with speech, such as: over- or underproduction; talks continuously or with intermissions; speaks only when spoken to; silent; answers questions relevantly or irrelevantly; speaks fast or slowly; rambles or keeps to the point; jumps from one subject to another;

invents new words (record words); appears to answer voices no one else hears; makes rhymes; jokes; shows definite trends (record nature of trend).

The following are useful words describing stream of talk:

evasive. Elusive.

fabrication. That which is made up or imagined.

fluent. Ready in the use of words.

garrulous. Wordy; talking much, especially about trifles.

hesitate. To falter in speaking.

incoherent. Ideas expressed are unrelated.

irrelevant. Not applicable or pertinent.

mute. Uttering no sound; silent, no structural change, psychic cause.

normal. The ordinary or usual condition.

obscene. Indecent; lewd.

profane. Unholy; irreverent speech.

pun. A play on words of the same sound but different meanings or on different applications of a word.

punning. Making puns.

rambling. Wandering; discursive.

rhyming. Making rhymes; speaking with cadence; making verses having a corresponding terminal sound.

sarcastic. Characterized by cutting gibes.

slurring. Pronouncing words indistinctly.

talking. Appropriate conversation.

vulgar. Unrefined, coarse talk.

voluble. Talkative, characterized by ease and smoothness.

Mood (Affect).—Mood refers to the state of mind, especially as affected by emotion.

Words describing mood include:

adequate. Fully sufficient; equal to or sufficient for the particular requirement.

angry. Enraged; keen displeasure; showing an actual outward display of anger.

blue. Low in spirits.

blunted. Callous; insusceptible of emotion.

cheerful. Lively; animated; having or showing good spirits.

depressed. Dejection of mind; dispirited.

elated. Connotes undue self-satisfaction; exaltation of spirit.

inadequate. Insufficient; falls short of the required situation.

inappropriate. Not appropriate; unsuitable; improper.

irritable. Easily exasperated.

sad. Low-spirited; evidence of grief.

suspicious. Distrustful; doubtful.

Projections.—A projection refers to subjective behavior projected or placed on something real, thereby giving it the appearance of reality.

Mrs. N. had a thin, rasping voice; she had her relatives take her to another hospital because she could not tolerate the rasping voices of the nurses.

Delusions; hallucinations; ideas of reference; ideas of influence; ideas of persecution; and fears, phobias, obsessions, and compulsions are specific projections.

A *delusion* is a fixed absurd false belief. (Note that nursing care makes no attempt to change a delusion.)

A *hallucination* is a false perception (relates to the senses). A person hears voices; sees pink elephants. Watch to see whether the patient talks with someone who is not present; study listening attitudes; record complaints about odors, visions, tastes, or sensations that indicate hallucinations. Hallucinations may be *auditory* (hearing), most frequent; *visual* (sight), common; *olfactory* (smell); *tactile* or *haptic* (touch); or *gustatory* (taste), uncommon.

The person with *ideas of reference* misinterprets the actions of others (or the environmental situation) as directed toward himself. A patient taking an anesthetic, for instance, hears laughter and thinks that people are laughing at him.

The person with *ideas of influence* considers that some thing or person controls his thoughts and feelings: electricity, magic, a group of people, or a particular person.

The person with *ideas of persecution* thinks that he is being annoyed, harassed, or pursued by a group of people (Masons, labor union, government) or a particular person (an immediate relative, an outstanding person such as a government official, a former employer, the hospital superintendent) with the intention of harming him. It is important to note that patients with ideas of influence or persecution are dangerous, especially when the projection finally centers on some one person, and mostly to that particular person.

A *fear* is a painful emotion caused by a sense of impending danger and accompanied by a desire to resist or escape; it is attached to a specific object. *Anxiety*, also a painful emotion caused by a sense of impending danger, is not attached to a specific object; it is really fear of fear. An important point to remember is that anxiety is very common in mental illness. When anxiety can be brought to a focal point and placed on something specific, treatment has progressed considerably, and from that point on treatment and care are easier for both patient and worker. Another important point is that anxiety uses up much mental energy.

A *phobia* is a fixed, morbid fear—an obsessive fear.

An *obsession* is an insistent, unwished-for repetition of a thought, e.g., a foul word or phrase. Obsessions are common in the neuroses.

An *obsessive-compulsive act* may be defined as follows: The obsessive thought leads to the compulsive act, that is, the obsessive thought makes the person act in a certain way (see definition of compulsive acts, below); the compulsive act is a defense against the obsessive thought.

A *compulsion* is a chronic, insistent, unwished-for repetition of an act; the action is due to an irresistible impulse and occurs in spite of opposition by the person's conscious will. A compulsive act is always a substitute for some other act, the other act being taboo. Compulsions are common in the neuroses.

A *compulsive act* is impelled by a morbid impulse which makes the person act in a certain way, e.g., washing the hands, actually or in movement; touching all objects in a room; or avoiding cracks in a sidewalk. *Compulsive ritual* is the term used to describe the activity of the person who arranges his life or things in a ritual fashion. This behavior is seen frequently in schizophrenic reaction.

Mr. C., in dressing or undressing, always wraps each article of clothing around a leg—chair, bed, bedside table—before putting it on or away.

Sensorium and Intellectual Reactions.—Sensorium refers to the clarity of the mental processes and relates to the orientative faculties; intellectual reactions refer to mental activity that is directed.

An awareness of one's surroundings is referred to as *orientation*; there are three recognized fields.

1. Time: year, month, day, age, date of birth, present season.
2. Place: country, state, city, location of home, present whereabouts.
3. Person: relatives, people around patient, self.

Disorders of sensorium include *confusion*, which may be defined as bewilderment (orientation is not clear); *delirium*, characterized by disorientation, which means that the patient is not aware of time, place, or person. If the disorientation relates to one field only, the person is said to be disoriented as to time (or place, or person).

A capacity to apply intellectual energy is referred to as *attention*. This capacity is tested by means of *attention tests*, of which the following are examples:

Bourdon's test. The person to be tested is given a page of printed material and instructed to cross out a certain letter, "a" or "b"; attention is graded on time and accuracy.

Marie's three-papers test. The person is given three pieces of paper and three directions concerning the papers—cross the room and throw one piece in the waste basket, put one piece on a table, and return the third to the examiner.

The faculty to remember is referred to as *memory*. *Past memory* includes remembering dates of events in the past life, such as date of birth, school events, and positions held. *Recent memory* is applied to remembering events of the last several months, weeks, or days, such as place of residence, events relating to the present illness, or food served at recent meals. Note that memory is the basis of association, the linking of one idea with another.

An estimate of the patient's ability in regard to *calculation and general information* is based on his educational background and past experiences. The patient's ability to calculate is tested by asking him to do problems in arithmetic, particularly in regard

to money transactions; to begin with 100 and keep subtracting 7; or to start with 25 and count backwards, etc.

The patient is expected to know outstanding points of interest, *e.g.*, the first President of the United States, the longest river in the United States, the approximate date of the Civil War, the location of the equator, legal holidays, recent world events—all of which come under the heading of *general information*.

The patient's ability in *reasoning and judgment* is based on how well he makes reasonable plans.

If *insight* is present, the patient is able to evaluate himself and understands that his symptoms are related to illness. When a patient who fears open spaces appreciates that the fear is a symptom of illness within his own mind and not founded in reality, he is said to have insight. Also, when a patient understands the explanation concerning his illness and the development of the symptoms, it is said that he possesses insight.

For psychiatric terms relating to this outline, see Glossary (Appendix II).

SAMPLE OF OBSERVATION

1. General appearance and behavior: slow, retarded, listless, apprehensive, indecisive; tires easily; lacks confidence; underestimates ability and achievement; skin dull, cold, moist, clammy; hair dry; fingernails brittle; muscles tense.
2. Stream of talk: slow, speaks very little; questions answered relevantly but slowly and almost inaudibly.
3. Mood (affect): depressed; downhearted; blue.
4. Projections:
 - a. Delusions of unworthiness and inadequacy, feelings of guilt.
 - b. Hallucinations: to dramatize delusions.
 - c. Ideas of reference: absent.
 - d. Ideas of influence: absent.
 - e. Ideas of persecution: absent or with feelings of guilt.
 - f. Fears, phobias, obsessions, compulsions: absent.
5. Sensorium and intellectual reactions:
 - a. Orientation: correct.
 - b. Attention: good when not completely occupied with depression and depression's difficulties.
 - c. Memory: good when accessible.
 - d. Calculation and general information: good.
 - e. Judgment: colored by mood.
 - f. Insight: present.

This sample of observation of behavior is given to show how the information obtained points to a general type or trend (depression); however, you rarely use the material in the aggregate. Your function is to record single items day by day on the chart, particularly in ward notes or nurses' notes. The outline provides a method of approach for organizing and stimulating ideas.

Physical Aspects. *Unity of Mind and Body.*—Emotional and physical health are intimately related. A person's mind is not something by itself. The human organism is a unit, and the separation of mind and body is artificial.

Unfortunately, in the struggle to grasp the new emphasis that is necessary when a patient becomes mentally ill—observing and recording what the patient says and does—there is a tendency to forget the patient as a whole and to overlook the physical aspects of fever, constipation, and pain.

When a person has a cold or is constipated, his equanimity is disturbed. Before menstruation many women show definite and consistent emotional reactions: Some are mildly depressed, others are especially sensitive, and still others experience stimulation with an accompanying urge to activity. Sorrow from the death of a loved one can take away appetite and sleep.

The very close relationship of the mental and physical is seen in medical diseases such as gastric ulcer, mucous colitis, bronchial asthma, and atopic dermatitis, in which the physical condition is either precipitated or exaggerated by situational or emotional factors. This field is receiving a great deal of attention under the name of "psychosomatic medicine."

Study the behavior of the postthyroidectomy patient; pay attention to the effect of emotion on speed in recovery of any illness; and notice healing of wounds of patients on surgical wards in relation to emotional states. Think about delirium. This is a well-known psychotic condition; yet when a patient on a medical ward becomes delirious, you do not ask the physician to add a psychiatric diagnosis or expect the patient to be transferred immediately to a hospital for the mentally ill.

In mental illness one is impressed with physical changes. There is a change in the quality of hair, the luster of the eye, the brittleness of the finger- and toenails, the texture and appearance of the skin. Body weight is stressed as an indication of mental states

evidence of the lifting of a depression appears in an increase in weight before an obvious change in the mood.

In psychiatric nursing, mental and emotional aspects receive special attention, but physical aspects do not have a lesser place. Psychiatric methods of treatment are physiological as well as psychological; a patient has to be in a fair physical condition before psychological treatment can be serviceable. Do not pigeonhole illness and care into mental or physical aspects but speculate on how much of each type of care is required.

Physical Symptoms.—A greater trust is placed in the nurse on the psychiatric ward in regard to recognizing physical symptoms than in any other branch of medicine. This particular angle requires special attention and study because body temperature is not taken as frequently as in a general hospital. It requires special attention, also, because the patient may not complain, or he may complain so frequently of physical ailments not supported by physical findings that it is easy to overlook an important disorder. The fact that stress is placed on the study of behavior throws one off guard, which means that one must be especially alert to physical symptoms.

Even though a temperature is not taken, you are expected to recognize the first sign of fever. When a woman of fifty uses a perineal pad each day, you are supposed to wonder why. Be careful about charting an old man as "untidy" when his real condition is prostate trouble with paradoxical incontinence. People with mental illnesses break their arms and hips; they become ill with colds, pneumonia, appendicitis, cholecystitis, nephritis, scarlet fever, in short, with any disease known to man.

Physical Symptoms Requiring Special Attention.—Watch especially for the following points:

1. Bruise. Bruises are important; report, record.
2. Complexion. Notice face—flushed, muddy, pasty, pale.
3. Constipation. Watch for fecal impaction.
4. Cough. Any cough is significant; watch old people.
5. Discharge. Notice, report, and record a discharge from any orifice.
6. Epidermophytosis. This fungous infection gives a great deal of trouble especially when patients walk about barefooted or exchange shoes.

7. Excitement. After any unusual period of excitement watch for physical symptoms. If an overactive patient lies down quietly in a corner but is not asleep, investigate for physical symptoms.
8. Excreta. Pay attention to urine, feces, perspiration, expectoration; notice amount, character, also behavior toward excreta.
9. Incontinence. Make sure of actual condition; see discussion under "Elimination," page 190.
10. Inflammation. Recognize the first signs of inflammation: redness, swelling, heat (pain may not be complained of by the patient); local loss of function is also a sign of inflammation, but the condition should be recognized before this symptom is present.
11. Lump. Notice any lump, particularly in the breast.
12. Menstruation. Irregularity in the menstrual periods is common; watch use or need of sanitary pads; pay attention to frequency, duration, amount, character, odor; know there is no chafing; observe behavior in relation to the menstrual period (whether there is a characteristic pattern preceding, during, or following the period; if so, it may be possible to predict restlessness, inactivity, overactivity, outbursts of activity, increased sensitivity with a tendency to misinterpret the actions of others).
13. Odor. Recognize the odor of pus, acidosis; body odors are hard to control (especially in hot weather and with elderly people) and no amount of bathing will remove an odor from a vaginal condition that requires medical or surgical attention. Perspiration is unpleasant and may be a sign of trouble. Axilla, hands, and feet are all offending areas, but perhaps the feet give the most actual distress.
14. Temperature, pulse, respiration. Notice change; be sensitive to a warm skin, a flushed face, a glassy eye. If you suspect an increased pulse rate, do not grab a watch in one hand and the patient's wrist in the other; learn to observe pulsating arteries in neck, face, temple; weigh the preceding activity and observe the patient for 10 or 15 minutes. Respiration is the least dependable; but, even so, it indicates physical and emotional states.

15. Vomiting. Any sign of vomiting requires investigation. The physician depends on you to report the actual condition: amount, type (projectile); consistency; color; time, particularly in relation to eating, visitors, and emotional situations; people present or absent; ease in vomiting. If an old man with a hernia begins to vomit, look for a hard lump; have the patient lie down; report to physician. Often the first and only measure is to raise the foot of the bed.
16. Wax in ear. With any sign of redness in the ear or beginning deafness, or if the patient scratches an ear, report to the physician and look for impacted wax.
17. Weight. The patient's weight is very important; a record of the weight is kept regularly—daily if indicated, otherwise weekly; record and report any abnormal loss or gain, or any general tendency.

RECORDING BEHAVIOR

Nursing Responsibility.—Regarding your reports on patient behavior, the content is always on objective aspects—specifically, on what the patient *says* and on what the patient *does*.

The efficient psychiatric nurse is adept in describing behavior. In this you do not utilize psychiatric terminology—hallucinations, flight of ideas, obsessions, etc.—nor do you venture on etiologies or attempt interpretations. You write simply what you observe. Your tool is ordinary language with stress on descriptive adjectives and adverbs. You know the meaning of certain words when someone else uses them, but a difficulty arises because you have not had to use these words in this particular way or describe situations or behavior in such detail and with such exactness.

Your record of the patient's behavior is a contribution to scientific literature. Descriptions of behavior, if discerning and clearly expressed, may become the basis on which important advances in the field of medicine will be made in the coming years.

Behavior Charts.—The behavior chart is a special form designed to furnish a condensed objective record of behavior; offer a method of systematized observation; provide a standard, permanent record; and present a graph showing significant behavior items, behavior trends and progress.

Value.—The behavior chart is of value because of its objective aspects—personal opinions are curtailed; speculation and interpretation are reduced to a minimum. It provides concrete training—a definite duty is demanded; specific symptoms are suggested. Finally, it is valuable because the reader gains useful information at a glance.

Responsibility.—The responsibility for this particular record rests with the head nurse.

Original Chart.—The original behavior chart came from the Henry Phipps Psychiatric Clinic of The Johns Hopkins Hospital. In 1914 the Kempf behavior chart (Dr. Edward F. Kempf) was developed from a chart worked out by Dr. Adolph Meyer.

Johns Hopkins Hospital Chart. The behavior chart opposite is a reproduction of the current form in use at the Henry Phipps Psychiatric Clinic.

In examining this form notice the following points:

1. The chart calls for a daily record.
2. The vertical columns represent one day (the day, or 24 hours, is considered from 7 A.M. to 7 A.M.).
3. The column at the left lists selected items of behavior.
4. The selected items of behavior are arranged in a planned order: The items are classified in five groups, separated by heavy black lines; the upper four groups cover spontaneous reactions of the patient. The activities placed in the second group from the top represent those expected of the person in normal health. The section above this indicates increased activity, the section below this indicates decreased activity (notice that the words measure progression).

In making the record a cross (X) is placed in the appropriate blank square. The marking relates to the intensity or persistence of the behavior: A full cross indicates that the activity is conspicuous throughout the day, a half-cross that the activity is moderate, a quarter-cross that the activity is present.

The record is kept wholly on an objective basis, and there should be statements by the patient or unmistakable behavior to justify charting. Whenever there is a question regarding a specific symptom, the matter is referred to the physician. Any unusual behavior recorded—suicidal, for example—should have details written up in the ward notes or nurses' notes.

FIG. 1.

At the Henry Phipps Psychiatric Clinic, detailed instructions on the behavior chart are incorporated in the nurses' routine book; these instructions include definitions of terms used on the chart.

FIG. 2.

Conferences are held regularly with the physician to clear up points of uncertainty, to preserve accuracy and unity of the chart, and to straighten out individual differences.

For additional information on the use of the particular chart, see the book by Steele listed in references under Textbooks for Nurses, page 163.

City Hospital (Cleveland) Chart. —This behavior chart was planned by Dr. Louis J. Karnosh and is a modification of the Johns Hopkins Hospital chart (see page 60).

Gardner Behavior Chart. —This chart was developed by Dr. Paul Wilcox at the Gardner State Hospital, East Gardner, Mass. The form is quite different from the Johns Hopkins Hospital chart. It is a rating scale of fifteen categories with each category subdivided into a five-point scale reading 0 to 4; the degrees of behavior are classified consistently.

The complete chart is a folder of four pages, of which pages 1 and 4 provide a key to the ratings, page 2 is the standard sheet for ward notes, and page 3 is the specific behavior chart on which is recorded the numerical score under the respective categories.

A reproduction of the chart is on pages 62-64.

Ward Notes or Nurses' Notes. —The form for the ward notes or nurses' notes is left entirely free for the written description of behavior. This record is more complete and specific than that of the behavior chart. It provides concrete training in mental exercise by stimulating intellect regarding fine points of behavior and developing vocabulary for describing behavior. Objective aspects of behavior provide the source material; however, the chart affords an opportunity for information on *quality* of behavior.

Changes in attitudes and ideational content can be recorded; variations within a few hours may be indicated, and there is some possibility for showing inadequate behavior that manifests little distortion of the behavior picture.

Making this record demands an able use of ordinary language, particularly descriptive adjectives and adverbs, and the ability to make a nice distinction in the use of words. It is unusual for a nurse to find this duty of describing behavior easy from the very beginning of study. A telegraphic style—demanded in the bedside note of general-hospital usage because of little space—is not acceptable; verbs are needed. The smoothness, the finish, and the construction of the sentence are all important, especially for your own exactness in thinking.

Name of Institution

GARDNER BEHAVIOR CHART

Last Name First Name

This behavior chart was developed in a state hospital for mental diseases and is particularly applicable to the periodic behavior analysis of the continued care cases. The period rated at one time usually should not be less than 24 hours nor more than 6 months. A conscientious nurse with a little supervision at the start can rate a patient fairly reliably if she consults her colleagues regarding those aspects of the patient's behavior which she is not in a position to observe herself.

Key to Ratings

In rating the patient's work consider the characteristics in relation to the particular task or tasks at which he is now occupied. If in doubt, put a question mark and add explanatory comments. Make use of all information available.

1. Attention to Personal Appearance.

- 1 — *Unidy* — Wets or soils or both. Indicate which.
- 0 — *None* — Slabbers his clothes and neither washes nor changes his clothes unless forced to.
- 1 — *Poor* — Does not slabber, but is untidy in general appearance and is physically rather dirty.
- 2 — *Fair* — Washes up an average amount and keeps his clothes tidy.
- 3 — *Good* — Keeps himself clean and neat most of the time. Takes some pride in his appearance.
- 4 — *Extra Good* — Very particular about being physically clean and about having his clothes clean and neat, and if possible, pressed.

2. Sleep.

- 0 — *None* — Seems to be awake day and night.
- 1 — *Poor* — Awake frequently during night, sleeps very lightly.
- 2 — *Fair* — Usually sleeps most of the night, but is occasionally restless.
- 3 — *Good* — Sleeps soundly all night, unless there is considerable commotion.
- 4 — *Extra Good* — A heavy sleeper, seldom disturbed by noises.

3. Appetite.

- 0 — *None* — Has to be tube fed.
- 1 — *Poor* — Eats very little, but will eat more when spoon fed.
- 2 — *Fair* — Eats a moderate amount when encouraged — usually leaves food on his plate after one helping.
- 3 — *Good* — Eats one large serving regularly.
- 4 — *Extra Good* — Usually asks for second or third helpings.

4. Sociability.

- 0 — *None* — Never talks or plays with others. Always exclusive.
- 1 — *Poor* — Almost always reclusive, will occasionally speak to others, but never joins in games.
- 2 — *Fair* — Converses with others a fair amount and may occasionally join in games.
- 3 — *Good* — Largely found talking or playing with others.
- 4 — *Extra Good* — Takes an active interest in others. Talks and plays freely with both patients and employees as opportunity arises.

5. Activity Control.

- 0 — *Aone* — Acutely restless. Stays in bed or in a chair scarcely five minutes at a time, or has prolonged periods of running up and down.
- 1 — *Poor* — Quite restless. Prolonged restlessness, though will stay in bed or in a chair for half hour periods. Started up by newcomers in the room or by commotion.
- 2 — *Fair* — Restless. Frequently moving about but does not run about. Will stay in bed or in a chair frequently for considerable periods.
- 3 — *Good* — Slightly restless at times but most of the time moves about only according to the demands of the situation.
- 4 — *Extra Good* — Not restless. No excess unnecessary activity.
- x — *Underactive* — Slow and sometimes motionless.
- y — *Motionless* — Frequently and for considerable periods motionless.

6. Noise Disturbance Control.

- 0 — *None* — Very disturbed, noisy most of the time, shouting, banging doors, etc.
- 1 — *Poor* — Rather noisy at times or a little noisy most of the time.
- 2 — *Fair* — Quiet most of the time, but moderately noisy occasionally, or frequent low mutterings.
- 3 — *Good* — Never causes noisy disturbance.
- 4 — *Extra Good* — Very quiet.

FIG. 3A. Page 1 of Gardner Behavior Chart folder.

FIG. 3B. Page 2 of Gardner Behavior Chart folder.

FIG. 3C. Page 3 of Gardner Behavior Chart folder.

Key to Ratings (continued)**7. Temper Control.**

- 0 — *None* — Flies off the handle at every little thing.
 1 — *Poor* — Loses temper easily, but can be handled, if done with care.
 2 — *Fair* — Usually controls his temper, but has spells of irritability.
 3 — *Good* — Seldom loses his temper, except occasionally when bothered.
 4 — *Extra Good* — Very seldom loses temper, even with provocation.

8. Combativeness Control.

- 0 — *None* — Is continually violent, attacking or fighting. Must be restrained or under sedation to protect others.
 1 — *Poor* — Assails patients and/or nurses nearly every day.
 2 — *Fair* — Occasionally assaultive.
 3 — *Good* — Never strikes except in self-defense.
 4 — *Extra Good* — If attacked, attempts to protect self without hurting the attacker.

9. Care of Property.

- 0 — *None* — Destructive of furniture and clothing much of the time, or steals constantly.
 1 — *Poor* — Occasionally destructive of furniture and clothing, or will sometimes steal.
 2 — *Fair* — Usually takes care of clothes, never destroys furniture, but will occasionally do minor damage to clothing, e.g., pulls buttons off, or occasionally steals food.
 3 — *Good* — Never intentionally damages furniture or clothing. Makes no petty thefts.
 4 — *Extra Good* — Always very careful about furniture, clothing, etc. Will assist in protecting property when asked.

10. Self-entertainment, including reading, writing, handicraft, or solitaire. Score and insert letters indicating the entertainment, *s*, *w*, *h*, and *a*.

- 0 — *None* — Absolutely idle or destructively occupied when not forced to work or play.
 1 — *Poor* — Only occasionally entertains self constructively except when urged to.
 2 — *Fair* — Entertains self of his own accord a moderate amount, but content to be absolutely idle for considerable periods.
 3 — *Good* — Usually entertains self in spare moments, but occasionally allows himself to be idle.
 4 — *Extra Good* — Always entertaining himself constructively when not working or mingling with others.

11. Cooperation in Routine.

- 0 — *None* — Is resistive to all routine procedures. Must be dressed and undressed and bathed by the nurses.
 1 — *Poor* — Will not move in routine unless the nurse takes him by the arm, when he will go without special resistance. Never responds to calls.
 2 — *Fair* — Will move to meals or to bed or bathe, etc., if called individually, but not when the group is called.
 3 — *Good* — Moves according to the group routine when others take the initiative.
 4 — *Extra Good* — Fits in with the routine very well. Goes to bed or to meals or bathes promptly on schedule without waiting for the rest of the crowd to lead the way.

12. Work Capacity.

- 0 — *None* — Entirely unable to learn this type of work, even after repeated instruction and demonstration.
 1 — *Poor* — Learns this type of work with difficulty and never is able to do it well.
 2 — *Fair* — Learns rather slowly, but in time gains considerable skill.
 3 — *Good* — Gets the idea quickly, and acquires skill quickly.
 4 — *Extra Good* — Gets the idea quickly without detailed instructions and does the task well from the start.

13. Work Initiative When Alone.

- 0 — *None* — Stops immediately, unless continually supervised or with other patients.
 1 — *Poor* — Makes only a little effort when not continually supervised or with other patients.
 2 — *Fair* — Makes an average effort when alone, but must be started.
 3 — *Good* — Can be expected to work well when not closely watched but may require starting.
 4 — *Extra Good* — Takes full interest and drives his work when alone. Needs but a minimum of supervision.

14. Work Initiative When Closely Supervised.

- 0 — *None* — Refuses to work while closely supervised or while with other patients.
 1 — *Poor* — Makes little effort when closely supervised or while with other patients.
 2 — *Fair* — Does fairly well when closely supervised or while with other patients.
 3 — *Good* — Works well while closely supervised or while with other patients.
 4 — *Extra Good* — Takes full interest, drives his work when closely supervised or with other patients.

15. Willingness to Follow Directions.

- 0 — *None* — Refuses to do the task assigned.
 1 — *Poor* — Does task assigned, but insists on doing it his own way.
 2 — *Fair* — Does task assigned, prefers to do it his own way, but does it as directed if closely supervised.
 3 — *Good* — Gladly (or willingly) does task as directed.
 4 — *Extra Good* — Very careful to do a task just as directed, and if in doubt, asks for further instructions.

FIG. 3D. Page 4 of Gardner Behavior Chart folder.

A sample of ward notes follows.

FIG. 4.

Suggestions on making ward notes are:

1. Begin with the date; record the description of behavior; initial the report.
 2. Use quotation marks around actual sayings.
 3. Indicate explanatory notes by parentheses.

		Nurses' Ward Report																	
Name	Ward	Hospital No.																	
Date		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature																			
Pulse																			
Respiration																			
Diet																			
Appetite																			
Tube fed																			
Fluid intake																			
Urine																			
Incontinence																			
Stools																			
Sleep																			
Sedatives																			
Occup't Th'py																			
Gymnasium																			
Blood pressure																			
Weight																			
Packs																			
Contin Tub																			
Cataractena																			
Seclusion																			
Shock B																			
Drug B																			
Date		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature																			
Pulse																			
Respiration																			
Diet																			
Appetite																			
Tube fed																			
Fluid intake																			
Urine																			
Incontinence																			
Stools																			
Sleep																			
Sedatives																			
Occup't Th'py																			
Gymnasium																			
Blood pressure																			
Weight																			
Packs																			
Contin Tub																			
Cataractena																			
Seclusion																			
Shock B																			
Drug B																			

FIG. 5.

- Record the behavior as you observe it; record any change in behavior, any unusual behavior, and be sure to have notes indicate the reasons for any special item on the behavior chart.
- Make the night record in red ink; the day, in black ink.
- Prepare the record for the actual day (7 A.M. to 7 P.M.).

once or twice, depending upon the amount and kind of activity (as with the behavior chart, the 24-hour period is usually considered as 7 A.M. to 7 A.M.).

7. Avoid falling into the rut of using only the terms "disturbed," or "quiet and cooperative."

Required Activity.—Required activity is recorded on individual sheets—weight chart, sleep chart, catamenial chart, hydrotherapy chart, occupational-therapy chart, etc.; but, besides this, it is helpful to have some information all in one place. Such information is recorded at the bottom of the behavior chart. If the hospital does not use a behavior chart, the required information may be recorded on the standard medical and surgical bedside note; in most hospitals, however, this record is used only for the first few days following admission and when the patient is physically ill. The bedside note is not adaptable to the needs of the psychiatric ward, and the bulk of such notes soon presents a critical problem. To meet the need in one hospital the writer devised a nurses' ward report, which is reproduced on p. 66.

Summary.

1. The nurse records objective behavior aspects only.
2. The tool is ordinary language.
3. Unusual items on a behavior chart should be inserted on the ward notes with details of the incident.

UNDERSTANDING (SYMPTOMATIC) BEHAVIOR

Laws and Principles.—The development of any science progresses in three major stages: first, the observation and collection of pertinent data or facts; second, the classification of these data into relevant groups or entities; third, the formulation of laws and principles to be derived from the facts. It may be argued that psychiatry is not a science because we are not yet arrived at the third and final stage of elaborating universal laws and principles in the study of the patient. Psychiatry may be taken to be in the second or classification stage and still divided into various schools of thought but observably approaching closer to a common ground as we near the third and final stage of formulation of general principles.

The Kraepelinian¹ period exemplifies the beginning of the second stage of development, the classification of the psychoses according to their symptoms. This was a tremendous advance, for previous to that time people with psychotic behavior had all simply been called "lunatics," and, if given a name, the illness was designated " hebephrenia" or "weak mind."

From this simple beginning, investigations and tremendous factual discoveries have built up a large body of knowledge. Universally accepted principles are as yet few, but two stand out, namely, that *the mind and the body are inseparable parts of a complete whole*, and that *there is a general tonus or set to the psychosomatic condition at a given time*.

Sigmund Freud in 1890 began publishing his fundamental observations on his theory of *the unconscious*. This psychoanalytic theory has done more than any other to stimulate the research and new approaches of modern psychiatry.

Until recent years the mind and the body were viewed as correlates rather than units of a whole. It is now well established that a pain can prevent a person from seeing the beauties of nature, speculating on a pleasant vacation, or figuring an income tax, and also that worry can produce indigestion or anxiety, cause trembling that occasions an ataxia, and prevent skilled utilization of finer movements. Today many textbooks begin with this starting point.

Regarding a tonus or set to the psychosomatic conditions at a given time, it is universally conceded that in a state of anxiety everything is comprehended as worrisome, that grief gives all experiences a sorrowful slant, that happiness contributes to happiness.

To date, psychology, and particularly psychology applied to nursing, is probably the outstanding (and possibly the only) course you have had on human behavior. Here the subject matter is a study of neurophysiological mechanisms. The material is objective, is aimed at general conceptions, and deals with the reactions of the masses. This study is essential and valuable as an introduction, but on the psychiatric ward you find that it does not clarify what you observe or orient you to the practical problems.

¹ Emil Kraepelin was a German psychiatrist who lived from 1856 to 1926.

On the ward you will observe the practice of a clinical, medical approach relating to deep levels of feeling and thinking—"depth" psychology—which, because of the stage of development, is individual and single in kind. Material is presented in case histories—a certain person reacts in a particular way to a specific experience or life situation. All contact with the patient is on an individual basis, although some group therapy, especially in the large hospitals, is being developed.

You, too, deal with the patient in an individual way. Your observation and care relate mostly to external, immediate, and environmental factors, but they are an important contribution to the total study and in helping you to understand the patient. A deeper understanding will come from your own interest and additional pursuit in the study of human nature, particularly the study of unhappy, destructive aspects.

When laws are formulated and principles established, the study of the patient will be unified and clarified, although one is unable to think of the subject matter as ever being simple.

Suggestions for Investigation.—The following suggestions are offered as pertinent subjects for investigation in reading, in examination of case histories, and in contact with patients.

Inner Peace. The patient's behavior is an expression of an effort to find relief from anxiety. All patients are people in trouble. In administering care you may do a good deed unawares, but you cannot be successful generally until the behavior has meaning. The patient looks to you for help. Above everything else he needs understanding; but even if you do not understand his behavior this one idea—the patient's effort to find inner peace—will give you something needful in nursing care.

No "Crazy" People.—Pathological behavior is intelligible if we make the effort to understand it and have all the facts at our command. One of the earliest lessons in psychiatric nursing is that you cannot sit as a judge, holding a patient accountable for willful misbehavior. Adrift as he is upon a powerful emotional stream, he may be carried helplessly from moment to moment into situations over which he has no intellectual control. His salvation lies in his own strength, and our failure to reach him from time to time may be due to the fact that he needs something more from us than mere shouts of encouragement.

Mr. A. is washing dishes. Every now and then he stops, shouts, and waves his arms about.

Unless locked up inside a person (fairly paralyzing him), emotional tension comes out in words and actions.

Every so often Miss T. calls out "bitch" three times.

This patient has vivid hallucinations of male organs and, in the background, auditory hallucinations of women swearing at her. Her particular reaction keeps the voices quiet for a time.

Mrs. S. goes through the motions of washing her hands.

This patient has tremendous feelings of guilt, and hand-washing is an effort to remove such an uncomfortable feeling state. (Recall "Macbeth," Act V, Scene 1.)

For about two weeks, whenever awake Mrs. W., a minister's wife, said dirty, nasty words fast and furiously.

Mrs. W.'s emotional explosion followed a particularly trying experience as counselor in a girl's summer camp. When it had quieted, she took her place in the community successfully as before.

A university professor was admitted to a psychiatric hospital because of throwing himself rolling to the floor at unexpected times.

He explained simply to his doctor that this behavior was a form of self-punishment and abasement for failure to keep his mind in channels he thought proper.

If you ever entertain friends with funny stories about "crazy" people, the joke is on you. You have eyes but as yet in reality you cannot see. Often the development of the power to see and understand is merely a matter of exercise, but its absence is closely linked to the blindness of boldness that overlooks inconveniences and dangers.

Subjective Behavior Aspects.—Accurate observation of objective aspects of behavior—what the patient says and does—is the field covered in the hospital record; an understanding of the patient's behavior, however, requires recognition of subjective aspects. As a competent expert you will have an untiring sensitivity to the patient's thoughts and feeling states.

Because of the danger of treading on the patient's chief complaint, this angle of study is not stressed enough. There is a large field of usefulness for the psychiatric nurse quite apart from the heart of the main problem. To be able to evaluate subjective behavior aspects is a real accomplishment, but your ability to understand and serve is limited by what you have experienced or impressions you have received.

From your own experience, do you know that patients talk to relieve distress and uneasiness, find fault when they are agitated and worn out by sleeplessness, complain to cover up embarrassment, are vivacious to hide shame, chat because their heads ache and they are sad, ask idle and misplaced questions when they are lonely and uncertain, or show fatigue because of a reserved internal sorrow?

Estimating the subjective aspects of behavior is an exacting matter. Think of the patient in a catatonic stupor. Is it not hard to realize that later he may tell everything that goes on around him? And consider the postencephalitic patient. Because of his masklike expression and seeming lack of interest, is it not difficult to appreciate that he understands and responds emotionally?

Be cautious in accepting impressions for reality and in adjusting opinion to appearances. Words and actions indicate moods and attitudes, but frequently there is a lack of unity between what the patient says and does and how he thinks and feels. You have to learn to see *through* the appearance of the situation to what is underneath.

Impersonal Characteristic.—Much of the behavior of the patient is unpleasant; however, unkind, hateful words, and unfriendly looks do not need to hurt. The behavior is not directed at you as an individual but is a symbolic expression of aggressions out of control. After a while you will see how fear, hatred, anxiety, worry, jealousy, frustration, loneliness, and inconvenience occasion many of the disagreeable aspects with which you have to deal. These feeling states have meaning for you. And when you see them as the cause of loudness, boldness, boastfulness, sarcasm, loquacity, sullenness, and hostility, there is no sting from the behavior itself. To reach this goal is a very important step in understanding the patient; however, when this point is reached the goal must be pushed further to an understanding of why he is fearful, hateful, anxious, worried, or jealous.

Time Factor.—You cannot hope to understand behavior simply because you witness a single act or conduct continued for only a short time.

Logic.—According to Webster, logic is defined as the science, art, or laws of exact reasoning, or of pure and formal thought. Logic relates to reality. The person who is frankly psychotic gets away from reality and his "logic" may relate to his mood or fantasy; again, the ideas may be sound but built on a false premise.

Mr. B., an engineer, claimed that the free-wheeling idea in automobiles was his and was stolen from him by the automobile company who used it.

The premise "stolen" proved false, but it took several years to prove that the man was suffering from a mental illness. His misstatement of fact was not a lie, as we commonly accept the term, but was an expression of wishful thinking on his part.

Mr. C. killed his wife and three children. He was brought to a hospital for examination. After delivering the patient, the accompanying policemen walked away [they always do even when several men turn a patient over to one nurse] saying that there could not be anything wrong with the man's mind because they had asked him everything imaginable and he could answer all of their questions and furthermore knew exactly what was going on. In a few minutes, the officers of the law overheard this bit of conversation:

Physician: Do you hear voices?

Patient: Yes.

Physician: Whose voice do you hear?

Patient: God's.

Physician: What does he tell you?

Patient: To save my family.

When a personality is completely disorganized it is fairly easy to recognize faulty judgment and inability to reason with exactness, but you may expect to meet certain patients whose diagnosis is not so evident. The personality disorder may be quite subtle and covered up, and you are not to conclude, as a lay person might do, from an hour's conversation with the patient or even after a month's acquaintance with him on the ward that he is perfectly well and unjustly detained. Intelligence may be intact and reasoning apparently sound, but the patient's judgment in relation to himself still may be warped by strong emotions.

People are often fooled by the general appearance of patients. It is so easy, on the spur of the moment, to misplace trust in the potential suicide or escape risk, and over and over again inexperienced nurses will allow some superficial personal criterion to outweigh professional judgment.

Sometimes the personality is obviously disorganized, sometimes reasoning and judgment appear sound until one touches on personal matters, again reasoning may be sound but with an incorrect starting point, the point of view may be warped, or there may be a lack of logical proportion when one estimates the total situation as against a single item.

Mature Love.—Mature love has a Godlike characteristic that makes its possessor desire and promote the welfare of others. Two important points to keep in mind are that love is a total personality reaction and that mature love must be developed.

Because the desired development or evolution of love is complete does not guarantee mental health, but faulty development means trouble. Mature love is necessary for the inner peace of the individual.

Mature love may also be necessary for the peace of nations. In the fourth century B.C. Aristophanes wrote, "From the murmur and subtlety of suspicion with which we vex one another, give us rest. Make a new beginning, and mingle again the kindred of the nations in the alchemy of love." Today psychiatrists such as Karl Menninger and Camilla Anderson (see references at end of this chapter) are saying that mature love is the medicine needed for the sickness of the world.

Emotional Maturity.—Emotional maturity means self-realization, the flowering of one's personality to its optimum. Like mature love it is achieved by life experiences, not simply inherited nor acquired by age.

Adolescence is a critical period. If the family relationships are healthy—particularly if the parents have sound and vigorous minds and there has been no special difficulty up to this time, probably adolescence will not present unsolvable personal problems. However, the social history of many patients shows pathological conditions taking definite form at adolescence.

During adolescence the person must bring childhood and adulthood into harmony with each other. The individual has an inner urge to become independent, but he also learns that inde-

pendence brings responsibility. Responsibility is decidedly uncomfortable until one learns how to carry it. So there is conflict between wanting to throw off parental dominance and attain independence and the desire to hold on to parental protection at the same time, thus avoiding discomfort of responsibility. Parents, too, have ideas on the matter.

If maturation is not successful, the individual continues through life insecure, uncertain, and restless; he is apt to be ineffectual and impotent; and, fundamentally, he remains superficial, irresponsible, and undependable. Ambitions continue unsatisfied; passions remain turbulent; success, if present, is by happy accident rather than achievement.

Destructive Forces.—On the wards, study the destructive force in unreasoning hatred, fear, anxiety, guilt, unresolved emotional conflicts. All behavior is motivated by the individual's need to secure satisfaction and avoid dissatisfaction. Usually the power of emotion is greater than that of reason, often dominating the intellect to the point of making intelligence its slave. Man offends against his own affections and destroys himself. The rebuke of Zeus in the "Odyssey" fits here: "Lo you now, how vainly mortal men do blame the gods. For of us they say comes evil, whereas they even of themselves through the blindness of their own hearts, have sorrows beyond which is ordained."

Psychological crimes—situations that bruise, cripple, smother, dull, suck, devour, crush, crucify the spirit and disorganize the personality—are commonplace and often occur within the protected environment of the home.

A great deal of difficulty is found in parental attitudes and training. Few parents know how to teach wholesome reactions to emotional crises, to train children to handle personal problems responsibly, or (and perhaps most important) to be wholesome patterns themselves. From a mental point of view, parents can cripple their children just as surely as though they threw them down the back stairs and broke their backs.

Many a mother, believing her son can do no wrong, lets his aggressions run wild. At the other extreme, any sign of budding maturity is interpreted as "disobedience," and the child is subdued to the point that he cannot ever acquire self-confidence or even assert himself except in the presence of those who are weaker than he.

One of the most damaging and common situations is the parasitic mother—the woman who, *because of a fear of life*, does not allow her children to have interests of their own so long as she needs their companionship and care. This is selfishness of the most vicious form and is particularly offensive because so often the victim is helpless and the cruel dominance can be made to appear warranted.

Sometimes parents dominate in an attempt to satisfy their emotional need for recognition (power). Power as an end in itself is a malevolent, destructive thing.

Mrs. R., aged twenty-six, is being brought back to the hospital from parole. She is a passive, weak-voiced, timid soul who has always been dominated by her mother. When Mrs. R. was twenty she obtained a position and was quite happy until the mother made difficulty with the employer.

At twenty-four she married, she and her husband got along nicely, but every so often the mother raised the ire of the husband through her demands. At one time he left his wife, at another he obtained a divorce. Shortly after the divorce Mrs. R. was admitted to the hospital.

After hospital treatment and care of 9 months she was ready for parole. The mother did not want her home because of the financial burden; the hospital placed the patient in the community on an earning basis. Matters went along nicely until the mother visited the daughter and the employer and raised trouble so that the employer no longer wishes to deal with the problem.

This is a single illustration but a common matter. To add insult to injury, these very situations that ruin lives are discussed under the name of, "love" and are looked upon with social approval and commendation. Language of emotion is not well understood.

There are parents who chide their daughter of thirty-five because she is still a burden on the family exchequer, yet they would not let her do anything that would have taken her away from their jurisdiction. Then there is the successful father who, forgetting his early struggles, expects too much of his son too soon. The children of broken homes frequently show a definite confusion regarding wholesome interpersonal relationships. The story goes on and on. The real tragedy is that often an adult cannot possibly make a satisfactory adjustment to reality because of inferior family stock or unhealthy family relationships.

Reserve Your Judgment.—More than symptoms of a specific illness is needed to understand the patient. The following cases are presented briefly to show a particular aspect, namely, that the patient is not a unique individual. His life, his trouble, his behavior have universal characteristics.

Mrs. F. has a history of becoming sick with headache and nausea beginning about Wednesday of each week; the symptoms increase until by Friday she is confined to bed. Mrs. F.'s husband is a minister who gives fine sermons when he spends time on their preparation, but his custom is to procrastinate until Saturday evening. The husband lost his good appointment; the wife came to the hospital.

Mrs. F. and Lady Macbeth have something in common. Following the killing of Duncan, Macbeth's increasing terror dominates the drama; and, while Lady Macbeth has reason to feel guilty, is not her fear in a large measure because of Macbeth's terror? In their husbands' behavior, do not Lady Macbeth and Mrs. F. alike see disaster for themselves?

Mrs. G. gives the following material during narcotherapy:¹

Mrs. G.: I made a little money by washing.

Physician: What did you do with the money?

Mrs. G.: I wanted to buy shoes.

Physician: Did you buy the shoes?

Mrs. G.: No, he found the money.

Mrs. G. furnishes the essence of an Anton Chekhov short story.

Mrs. S. is not accepted by her husband's parents. The husband's father is the head of a large industry and has great plans for his son including a different type of woman for his wife.

The history of Mrs. S. corresponds to that of Lucy Desborough in "The Ordeal of Richard Feverel," by George Meredith.

Mrs. W. was brought to the hospital following an attempt at suicide. Her marriage was an unhappy one; she left her husband to live with another man out of wedlock.

Mrs. T. is narcissistic and homosexual. Although at present a human wreck, she is still beautiful. She began life almost as a street urchin but at one time was married to a millionaire. Men clamored for her attention but actually she had very little to give.

¹ This incident was contributed by Mrs. R. W. Robb.

Regarding the last two cases, Mrs. W.'s life presents the skeletal idea of "Anna Karenina," by Count Leo Tolstoy, and Mrs. T., of "Nana," by Émile Zola. When these two books appeared in the movies, people—particularly women—said of Anna that death was what she deserved and of Nana that death was not enough.

It is easy to say how a person should behave. But tragedy touches the lives of the masses, and few appreciate the entangled elements in the individual situations. The average person has little understanding of the problems of the masses or the mechanisms of behavior and not even a primer acquaintance with pathological features.

As you deal with patients you too will question and sometimes condemn, but after a while you will see universal characteristics and accept the fact that there must be fundamental, basic factors. If tempted to pass judgments, appreciate that you may not know all the facts and that objectivity needs a conscience. Recall Plato's instruction that whoever undertakes to judge another man must have three virtues: be informed, and bold, and kind.

Approach to Study. —In trying to understand the patient's behavior it may help to organize ideas around the following headings: vital human needs, resources for meeting these needs, environmental factors, and the interaction of these agents.

The term *vital needs* refers to fundamental human drives: self-preservation; recognition; affection—both to receive and to give; opportunity to express talents and to work toward satisfying goals; a satisfying relationship between abilities and production, ideals and accomplishments.

The patient's *resources for meeting vital needs* relate to: aptitudes and intelligence; emotional maturity; physical health; amount, mobilization, and utilization of energy; education; faith (religion); character traits—reactions as a whole (self-determined); personality qualifications—hopes, fears, ambitions, prejudices, thoughts and feelings, especially point of view; established pattern of reaction. An illustration of a behavior pattern is the following:

Being married to a heavy drinking man with little income, Mrs. N. experiences a living hell. This is her third unhappy marriage to the same type of man.

The *environmental factors* to be considered relate to the social background and related problems, specifically, early life expe-

riences; domestic problems; family relationships; business and professional relationships; economic condition; cultural factors; situations that provoke frustration, guilt, hatred, fear, anxiety; war.

In studying the illness of any patient the above-named angles and their *interaction* are viewed and weighed. Heredity and environmental factors, particularly early life experiences, definitely affect the character and personality of an individual. In turn, the character and personality represent the foundation of resources for dealing with life problems. The study is complicated, and as yet no single factor is known to be the determinative causative agent.

A definite life situation may be a precipitating cause, but some factor in addition is involved, because all people experiencing the same life situation do not become mentally ill. People do not respond in the same way to similar stimuli. Cervantes' early life was just as difficult as Swift's, but his writing ("Don Quixote") reveals no bitterness or hatred of mankind.

Regarding stress as a precipitating factor, there is no particular load nor numerical amount of load that causes an illness. It is a particular load for a particular person at a particular time that is important. Difficult life situations or catastrophes may uncover a psychological predisposition, may precipitate a personality disturbance, or exaggerate a minimal disturbance.

Poor physical and mental equipment (constitutional) or faulty mental development (early training) may prevent a person from becoming effectual and attaining a solid satisfaction in living.

In any event the study of a patient should focus always around himself. People (patients) are not alike. They differ in physical make-up, gifts and capacities, education, life experiences, reactions to life experiences. It is not fair to compare one patient with another; the comparison is not drawn from the same relative position. In fact, people differ so much that a life situation which disorganizes one personality may save another from destruction.

The patient's entire background—biological factors, particular emotional stress, orientation, memory, attitude toward symptoms—is as important as are the objective aspects of his behavior.

Speculative Aspect.—Understanding the patient's behavior is a highly speculative endeavor. Much of what you need to know is not evident and often not at your command. Sometimes it

relates to unhappy personal matters which the patient cannot accept himself and tries to keep from the eyes of the world. Add to this the fact that the patient may react to situations as he fancies them rather than as they are, or that he makes shifts in the meaning and importance of words to suit himself. All this makes the behavior of the patient out of line with objects and situations as you view them.

The understanding of behavior presents a problem to be solved in the same way as any other problem having unknown factors—through the use of intellect. You should be constantly adding, combining, comparing, and drawing conclusions. However, your analyses and syntheses are used for hypothetical purposes, and postulates must be kept fluid. They should change from day to day as you gather additional information on the patient's way of thinking and feeling; learn new facts about his ambitions, ideals, frustrations; see different angles; and discern new relationships. In other words, know more about the patient as a person and psychiatry in general. Avoid the Scylla of bland, self-complacent pigeonholing of all patients with similar behavior and the Charybdis of meeting each problem as a totally new experience, totally unrelated to anything you have previously known or studied about in the classroom.

For additional material on understanding the patient's behavior, see the section on literature, page 298.

MODIFYING BEHAVIOR

Modifying Moods, Changing Attitudes.—Modifying moods and changing attitudes, especially at the point of contact between the patient's state of mind and the therapeutic need, are the principal objectives in psychiatric nursing and form the bulk of the material in this book. In meeting these objectives you learn to manipulate human relations under the most trying condition: namely, the other person (the patient) is unable to carry on his obligation and responsibility regarding a harmonious interpersonal relationship.

Nurses write knowingly on examination papers about patience, tact, and understanding, yet on the ward they expect a patient to be punished for unsocial behavior, they drop responsibility as soon as the patient is informed of something he should do, and

they threaten a patient with a wet pack or transfer to another ward (inference, "worse" ward) if he does not control his behavior. In psychiatric nursing you do not punish, throw responsibility on the patient, or threaten; you educate, carry the patient's responsibility until he can carry it himself, and—until such time as the patient is able to deal successfully with unpleasant realities—you create situations that tend to keep behavior from getting out of control.

Vital and adequate nursing care requires a capacity to observe, to understand, and to modify behavior away beyond even the conception of the average nurse at the present time.

Most Adequate Tool.—The most adequate tool for modifying moods and changing attitudes is *your own behavior*. In time the patient tends to respond to you as you act toward him, *providing you are consistent in your dealings with him*.

Psychiatric nursing is largely a search for a key to release the patient's more amiable feeling states. Many of the illness symptoms are associated with deep-seated causes and may not be influenced quickly or directly by nursing care, but much of the behavior of the moment is due to occasions of an immediate and external nature.

Difficulties.—Specific difficulties in modifying pathologic moods and unwholesome attitudes are: the nonflexible quality of the patient's moods and attitudes and his unpredictable behavior; the complexity of situations; the need to change your own natural attitude; and the demand for self-impetus.

Nonflexible Quality.—One of the striking differences in caring for patients who suffer predominantly with mental rather than physical illness is the rigidity of moods and attitudes. This is frequently accompanied by a narrowed horizon, a warped point of view, or an inexorable logic. The specific difficulty is to find a starting point.

In the beginning of any patient-nurse relationship you may not know when you have made a satisfactory contact. Attitudes change, and even the mood changes over a period of time, but the dispiriting aspect for you is not being able to know how much you control any single situation. Always you must work toward an accumulative effect by next week or next month, live in a state of expectancy, and learn not to be disheartened when your hopes do not materialize as soon as you think they should.

Unpredictable Behavior.—One of the surprising conditions you will encounter is that occasioned by unpredictable behavior. Often the patient does not react in the way you expect. When you are kind you may not be shown kindness; you and the patient may not call the same thing by the same name; his emphasis may be different from yours; what you say may mean something quite different to him from what you intended. The specific difficulty is to find a common meeting point.

Do not worry too much about these unexpected reactions. Prevent accidents if possible, but do not spend time trying to meet the patient on unhealthy ground. For example, if you say something kind and the patient responds with something decidedly unfriendly, do not stop saying kind things as occasion arises. If a patient calls a chair a throne, do not argue but do not accept his idea and call it a throne. In other words, deal with these situations realistically. You are the stable, wholesome factor in these unwholesome situations, and as you and the patient learn more about each other, the behavior usually becomes less unpredictable. Appreciate that the patient, too, has to learn that he can depend on your reactions.

Complexity in Situations. You deal with a live subject and, therefore, with one that is in a constant state of motion. The parts of any situation—the patient, his environment, and their relationships to each other—change from day to day, minute to minute. Also in any patient-nurse relationship you are never in the beginning of any incident. You are always in the middle of something in which you are only one factor and about which you cannot perceive all components.

In part the patient's reactions are psychodynamically conditioned by mechanisms inexplicable to himself as well as to you. You may be giving excellent care, yet some other nurse may have a much greater influence over the patient only because of a gold filling in a front tooth or a twinkle in the eye that makes him think of someone for whom he has deep affection.

Changing a Natural Attitude. To deal therapeutically with pathological behavior, you have to change your own natural attitude.

On the surface many psychiatric patients are unpleasant, nasty, self-centered, despicable people. And what person truly likes to be with those who always talk about stomach gases, constipation

headaches, a fluttering, throbbing heart; who misinterpret everything, take offense easily, do not speak, or make cutting remarks; or who are irritable, fault-finding, overapprehensive, or shed tears copiously; or who are sarcastic, indifferent, indecisive, obscene?

It is largely because of his asocial and antisocial behavior that the person is removed from a community and placed in a hospital. And you are obliged to deal daily with interpersonal relationships that in life arouse one to anger or impel him to turn away, or to look upon the offender with indifference, pity, dislike, disgust, contempt, or hostility. Relatives and associates cannot tolerate the behavior. You do not like it either, but you learn to change your own natural reactions.

Strong emotion, such as that witnessed in patients, is infectious or produces reactions antagonistic to efficient care. It is natural to feel subdued in the presence of sadness, to be annoyed when dealing with anger, to be hurt by sarcasm, to leave confirmed Niobian creatures alone, to cringe or fight in the presence of destructive aggression. In the midst of so much emotional chaos, you have to learn not only to maintain an emotional equilibrium but to act in a way that will modify the patient's reactions.

When your own natural attitude is undesirable make use of the following steps:

1. Change the stimuli. This means to look for the cause of the unpleasant behavior. If you do not understand the details, keep before you the idea that the behavior is the patient's effort to find peace.
2. Think about nursing objectives and how to bring them about. This brings with it an urge to do something concrete. However, when your course of action is not established either by others through routines, or by yourself through slowly accumulated intellectual judgments, you may feel helpless. At this point if the desire to go ahead is greater than a natural resistance, you will decide to act.
3. Put reasoning and judgment into effect.
4. Observe results.

In dealing with pathological behavior, if you do not experience a definite intellectual process going on within yourself, you are not nursing on a professional level. If you have no problem, very likely you are indifferent and have little insight as to the patient's

needs and your own obligations and responsibilities. This matter of changing a natural attitude is very difficult to teach male attendants. "You son of a bitch" are fighting words to the average man. Incidentally, the presence of women on male wards noticeably reduces this kind of behavior. All men tend to rise to the height of a gentleman in the presence of a lady.

(Early in her psychiatric experience in dealing with unpleasant behavior the writer used to say to herself just the opposite of what came to mind; *e.g.*, when a patient was horrid and "My, you are hateful" came to mind, this was replaced with "My, you are lovely." No doubt such a method is unscientific, but it introduced a lighter vein for the worker and helped to control natural emotional reactions until some insight into symptomatic behavior was acquired.)

Demand for Self-impetus. Stimulation for nursing activity comes largely from within. Orders from physicians are not numerous, except on admission and on disturbed wards; routines are not uncomfortably heavy; the patient himself is usually indifferent to what goes on. There is another angle—the stimulating activity in a rapid turnover of patients, particularly the discharge of well patients after short contacts, is missing.

Without a self-imposed drive, monotony and a dimming in observation are probable. Important changes in behavior will not be recognized until anyone could see them; early symptoms of cancer and tuberculosis will be overlooked. You have to initiate positive action. This places a premium on your own attitudes, motives, and objectives. Imaginative stimuli are necessary, and ideals must crystallize vague ideas into effective desire.

REFERENCES

BOOKS¹

- ALDRICH, C. A. and MARY M. ALDRICH: "Babies Are Human Beings. The Interpretation of Growth," The Macmillan Company, New York, 1939.
- ALVAREZ, WALTER C.: "Nervousness, Indigestion and Pain," Paul B. Hoeber, Inc., New York, 1943.
- ANDERSON, CAMILLA M.: "Emotional Hygiene," 3rd ed., J. B. Lippincott Company, Philadelphia, 1943.
- ANGYAL, A.: "Foundations for a Science of Personality," Commonwealth Fund, New York, 1941.

¹ See list of textbooks for nurses on page 163.

- APPEL, KENNETH and EDWARD STRECKER: "Practical Examination of Personality and Behavior Disorders," The Macmillan Company, New York, 1936.
- BAKWIN, R. M. and H. BAKWIN: "Psychological Care During Infancy and Childhood," D. Appleton-Century Company, Inc., New York, 1942.
- BOSSARD, JAMES H. S. and ELEANOR S. BOLL: "Family Situations. Introduction to the Study of Child Behavior," University of Pennsylvania Press, Philadelphia, 1943.
- BROWN, J. F. and KARL A. MENNINGER: "Psychodynamics of Abnormal Behavior," McGraw-Hill Book Company, Inc., New York, 1940.
- BROWN, J. F.: "Psychology and the Social Order," McGraw-Hill Book Company, Inc., New York, 1936.
- BURLINGAME, L. L.: "Heredity and Social Problems," McGraw-Hill Book Company, Inc., New York, 1940.
- COBB, STANLEY: "Foundations of Neuropsychiatry," 3rd ed. rev., The Williams and Wilkins Company, Baltimore, 1944.
- CHRISTIAN, HENRY A., Editor: "Psychiatry for Practitioners," Oxford University Press, New York, 1936.
- DESPERT, J. L.: "Emotional Problems in Children," State Hospitals Press, Utica, N. Y., 1938.
- DUNBAR, FLANDERS: "Emotions and Bodily Changes: A Survey of Literature on Psychosomatic Interrelationships," 2nd ed., Columbia University Press, New York, 1938.
- FAEGRE, M. and J. ANDERSON: "Child Care and Training," University of Minnesota Press, Minneapolis, 1943.
- FREUD, A. and D. BURLINGHAM: "War and Children," International University Press, New York, 1944.
- FREUD, SIGMUND (A. A. BRILL): "Psychopathology of Everyday Life," 16th impression, Ernest Benn, Ltd., London, 1935.
- GOLDSTEIN, K.: "Human Nature in the Light of Psychopathology," Harvard University Press, Cambridge, 1940.
- GRINKER, LT. COL. ROY and MAJOR JOHN P. SPIEGEL: "Men under Stress," The Blakiston Company, Philadelphia, 1945.
- HART, BERNARD: "The Psychology of Insanity," 4th ed., Cambridge University Press, London, 1934.
- HILLYER, JANE: "Reluctantly Told," The Macmillan Company, New York, 1931. (Biographical.)
- HINSIE, LELAND E. and JACOB SHATZKY: "Psychiatric Dictionary," Oxford University Press, New York, 1940.
- HINSIE, LELAND: "The Person in the Body. An Introduction to Psychosomatic Medicine," W. W. Norton & Company, Inc., New York, 1945.
- HORMAN, LESLIE B.: "As the Twig is Bent," The Macmillan Company, New York, 1940.
- HUNT, J. MCV., Editor: "Personality and the Behavior Disorders," The Ronald Press Company, New York, 1944. (Particularly Vol. I, Part I, "Theoretical Approaches to Personality," Part IV, "Determinants of Personality—Biological and Organic," and Vol. II, Part V, "Determinants of Personality—Experiential and Sociological.")

- HUTCHINGS, R. H.: "Psychiatric Ward Book," 7th ed., State Hospitals Press, Utica, N. Y., 1943.
- JENSEN, DEBORAH M.: "An Introduction to Sociology and Social Problems," The C. V. Mosby Company, St. Louis, 1943.
- JONES, ARTHUR J.: "Principles of Guidance," 3rd ed., McGraw-Hill Book Company, Inc., New York, 1945.
- JONES, HAROLD E.: "Development in Adolescence," D. Appleton-Century Company, Inc., New York, 1943.
- LANDIS, PAUL H.: "Adolescence and Youth, The Process of Maturing," McGraw-Hill Book Company, Inc., New York, 1945.
- LANGER, WALTER C.: "Psychology and Human Living," D. Appleton-Century Company, New York, 1943.
- LEWIN, K.: "A Dynamic Theory of Personality," McGraw-Hill Book Company, Inc., New York, 1935.
- LEVY, DAVID M.: "Maternal Overprotection," Columbia University Press, New York, 1943.
- LEVY, J. and R. MONROE: "The Happy Family," Alfred A. Knopf, New York, 1941.
- LOWY, SAMUEL: "New Directions in Psychology—Toward Individual Happiness and Social Progress," Emerson Books, Inc., New York, 1945.
- MCNEMAR, Q. and M. A. MERRILL: "Studies in Personality," McGraw-Hill Book Company, Inc., New York, 1942.
- MALAMUD, WILLIAM: "Outlines of General Psychopathology," W. W. Norton & Company, Inc., New York, 1935.
- MASLOW, A. H. and BELA MITTELMAN: "Principles of Abnormal Psychology," Harper & Brothers, New York, 1941.
- MENNINGER, KARL A.: "The Human Mind," 3rd ed., Alfred A. Knopf, New York, 1945.
- MENNINGER, KARL A.: "Love Against Hate," Harcourt, Brace and Company, New York, 1942.
- PEARSON, GERALD: "The Psychiatry of Childhood." "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- PRESTON, GEORGE H.: "Psychiatry for the Curious," Farrar & Rinehart, Inc., New York, 1940.
- RIBBLE, MARGARETHA A.: "The Rights of Infants," Columbia University Press, New York, 1943.
- RIGGS, A.: "Just Nerves," Doubleday, Doran & Company, Inc., New York, 1922.
- SAYLES, M. B.: "The Problem Child at Home," Commonwealth Fund, New York, 1928.
- SCHILDER, PAUL: "Goals and Desires of Man—A Psychological Survey of Life," Columbia University Press, New York, 1942.
- STRECKER, E. A. and K. E. APPEL: "Discovering Ourselves: A View of The Human Mind and How It Works," 2nd ed., The Macmillan Company, New York, 1943.
- STRECKER, E. A. and H. B. PALMER: "The Recognition and Management of the Beginning of Mental Disease." "Psychiatry for Practitioners,"

- Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- TOMPKINS, SILVAN S., Editor: "Contemporary Psychopathology," Harvard University Press, Cambridge, 1943.
- TRAVIS, LEE and DOROTHY BARUCH: "Personal Problems of Everyday Life," D. Appleton-Century Company, Inc., New York, 1941.
- VALENTINE, G. W.: "Psychology of Early Childhood," Methuen & Co., Ltd., London, 1942.
- WASHBURN, RUTH W.: "Children Have Their Reasons," D. Appleton-Century Company, Inc., New York, 1942.
- Webster's Collegiate Dictionary, G. & C. Merriam Company, Springfield, Mass.
- WEISS, E. and O. S. ENGLISH: "Psychosomatic Medicine," W. B. Saunders Company, Philadelphia, 1943. (The clinical application of psychopathology to general medical problems.)
- WOLF, A. W. M.; "The Parent's Manual—A Guide to the Emotional Development of Young Children," Simon and Schuster, Inc., New York, 1941.
- WOLF, WERNER: "The Expression of Personality; Experimental Depth Psychology," Harper & Brothers, New York, 1943.
- ZACIRY, CAROLINE B.: "Emotion and Conduct in Adolescence," D. Appleton-Century Company, Inc., New York, 1940.
- ZILBOORG, GREGORY: "Mind, Medicine and Man," Harcourt, Brace and Company, New York, 1943.

ARTICLES

- BERGLER, EDMUND. "On the Disease Entity Boredom ('Alysosis') and Its Psychopathology," *The Psychiatric Quarterly*, January 1945, pp. 38-51.
- BURROW, TRIGANT. "The Human Equation," *Mental Hygiene*, April 1941, pp. 210-220.
- CLARK, W. E. LE CROS. "The Anatomy of the Nervous System," *The Journal of Mental Science*, January 1944, pp. 36-53.
- COLEMAN, W. H. "Psychopathology," *The Journal of Mental Science*, January 1944, pp. 152-192.
- CORSON, HAROLD F. "A Study of the Behavior Chart in Cases of Thymegasia," *The American Journal of Psychiatry*, July 1931, pp. 73-102. (Primary affective disorders.)
- DAVIDSON, G. M. "Further Observations on Hallucinations of Smell," *The Psychiatric Quarterly*, October 1945, pp. 692-696.
- DYNES, COMDR. JOHN B. "Mental Breaking Points," *The New England Journal of Medicine*, January 10, 1946, pp. 42-45.
- ERICKSON, M. R. "The Early Recognition of Mental Disease," *Diseases of the Nervous System*, February 1941, pp. 99-108.
- FARRELL, LT. COL. M. J. and LT. KATHLEEN ATTO. "Wartime Stresses and Neuropsychiatry," *The American Journal of Nursing*, July 1943, pp. 634-640.
- FOX, ARTHUR N. "An Approach to the Psychology of Indifference," *The Psychoanalytic Review*, July 1945, pp. 296-299.

- GERO, GEORGE. "The Idea of Psychogenesis in Modern Psychiatry and Psychoanalysis," *Psychoanalytic Review*, April 1943, pp. 187-211.
- GOLLA, F. L. "Physiological Psychology," *The Journal of Mental Science*, January 1944, pp. 54-63.
- HACKER, FREDERICK and ELIZABETH GELEERD. "Freedom and Authority in Adolescence," *The American Journal of Orthopsychiatry*, October 1945, pp. 621-630.
- HANKINS, DOROTHY. "The Psychology and Direct Treatment of Adolescents," *Mental Hygiene*, April 1943, pp. 238-247.
- KANNER, LEO. "Early Behavior Problems as Signposts to Later Maladjustments," *The American Journal of Psychiatry*, May 1941, pp. 1261-1271.
- KEMPF, EDWARD J. "The Behavior Chart in Mental Diseases," *The American Journal of Insanity*, April 1915, pp. 761-762.
- RIEMER, MORRIS D. "Psychology of Ideas of Influence," *The Psychiatric Quarterly*, July 1939, pp. 401-418.
- RUGE, ANNE. "The Behavior Chart," *The American Journal of Nursing*, May 1934, pp. 428-432.
- SLATER, ELIOT O. "Genetics in Psychiatry," *The Journal of Mental Science*, January 1944, pp. 17-35.
- SULLIVAN, H. S. "Psychiatry: Introduction to Study of Interpersonal Relations," *Psychiatry*, February 1938, pp. 121-134.
- WEISS, EDWARD. "Psychosomatic Medicine," *The American Journal of Nursing*, March 1945, pp. 189-193.
- WILCOX, PAUL H. "The Gardner Behavior Chart," *The American Journal of Psychiatry*, May 1942, pp. 874-880.
- WILGUS, KATHARINE A. "Psychiatric Behavior Study," *The American Journal of Nursing*, January 1931, pp. 97-100.

CHAPTER III

NURSING CARE: REMEDIAL APPROACH

Meaning. The emotional reactions of most patients are largely negative, and in your contact with the patient you either lessen or deepen these negative reactions. This gives the approach to the patient a basic place in the study of effective nursing care. It is the initial step in modifying behavior—the principal objective in psychiatric nursing.

Objectives. The outstanding objectives in a remedial approach to the patient are *to weaken and lessen negative emotional reactions and to initiate, stimulate, and strengthen wholesome emotional reactions.*

The material that follows refers wholly to patient-nurse relationships. The activities suggested require mental exertion rather than physical; receptive and reflective powers must be developed to a high degree.

Activities include immediate nursing activities and those extending over a long period. (Direct nursing activities, you will recall, usually relate to physician's orders for which a definite procedure is established; at such times modifying moods and changing attitudes are not overlooked but, for the moment, have a secondary consideration.)

The use of verbs in the present tense—reduce, use, arouse, etc.—is to convey the idea of a positive, active function.

Regarding a remedial approach to the patient, matters of primary importance are:

1. Reduce fear.
2. Use the admission procedure as a strategic opportunity.
3. Arouse interest.

Reduce Fear. The greatest blanket aid in lessening negative emotional reactions is to reduce fear. With patients who are mentally ill, fear is frequently an inherent part of the illness; many fears, however, are caused by external and clearly observable

factors. To appreciate the crippling effect of fear think of yourself as standing on a circular area 12 inches in diameter and then imagine this area as being raised some 500 feet into the air.

On the psychiatric ward all patients sooner or later give evidence of being afraid. Specific and vague fears abound. Fear is the most common cause of unpleasant behavior in patients. Over and over again the patient who will not cooperate, will not eat, who is unresponsive, hateful, demanding in fact most of the behavior that is so hard to deal with often has fear in the background as the motivating factor. On the medical and surgical wards fear holds a more important place in the behavior of the patient than nurses realize until they have had experience on psychiatric wards. Fear is obvious in patients with agitated depression, with some psychoneuroses, and in most patients following admission.

Characteristic Reactions. Misinterpretations and misunderstandings come easily to patients who are under the influence of fear. In reacting to fear patients often fight, as shown in aggressive, domineering, demanding, even hostile behavior. These are the "uncooperative" patients. Others ask for attention and repeated assurance, hoping to find security in your voice, manner, general kindness. These are the "miserables." Still others lock their fear inside themselves, which may be overlooked easily. These are the "good" patients.

Fear, like pain, fever, or bone crepitus, is an indicator of internal conditions that are to be remedied.

Provide Security. Nursing care centers around ways to provide security. The principal avenue of approach is through the environment, particularly through your own general attitude and behavior. Important points are:

1. Show a sincere interest in the patient's welfare. This will initiate faith and provide confidence through a sense of importance. Just to know that someone is interested is a secure experience that has healthful, expansive powers.
2. Orient the patient to his surroundings and to what is expected of him. The patient who is newly admitted is introduced into an unfamiliar environment, the unknown factors of which disturb his equilibrium and cause fear. New fears strengthen and bring forth old fears. Inform the

patient regarding the place (where he is, the location of the bathroom, the use of plumbing, the dining room, what time he will eat); the people (doctors, nurses, attendants, neighbors with whom he will be associated—introduce him to them or give name and description); activities (ward and hospital routines). Give the information just previous to the need. Tell the patient about his privileges, his restrictions—in general, his obligations and responsibilities in the hospital life.

3. Prevent change, so far as possible, especially for newly admitted patients until they become accustomed to the new surroundings, and for those who are confused. Have them stay in the same bed, seated at the same place at the table, say the same things the same way each time. Have the same nurse give detailed care for several consecutive days or longer, depending upon the patient's condition. Additional stimuli, strange people, and unlike ways of doing things all add to the confusion and distress of the person who is not familiar with his surroundings.
4. Attend promptly to requests.
5. Carry out all promises.
6. Be dependable and friendly.
7. Use a soft, clear, low voice.
8. Exert a calm touch.
9. Do not make thoughtless remarks.
10. Do not be critical and dominating.
11. Do not hurry; develop an easy, comfortable gait.
12. Never show irritation.
13. Reassure verbally. This does not mean to tell the patient he will feel better tomorrow, next week, or that he will be well next month. Reassurance must be in relation to positive things—faith in the hospital personnel, especially the physician; treatment; and the present as improvement over the past.
14. Help the patient build faith in himself. Regard him as a person who thinks; respect his personality, his individuality; increase his own self-respect. Attend to personal appearance, introduce order, give praise whenever due, increase confidence in his own positive capacities; respect his personal property; be generous with individual attention.

15. Be objective, consistently fair, firm and decisive, and, at the same time, kind and tender.
16. Make certain that the patient is familiar with wholesome, healthy goals and requirements for advancement and greater personal freedom. The physician will give suggestions.

Most patients are afraid, and the importance of the transfer of feeling tones makes it necessary not to be afraid of patients. Sometimes a young nurse is afraid, particularly on a "disturbed" ward where aggressive behavior is foreboding and unpredictable reactions make the observer feel insecure. Knowledge and experience remove this fear.

Use the Admission Procedure as a Strategic Opportunity. —The main objectives in the admission procedure are *to have the patient feel that the hospital is his protector and benefactor and to have the patient sense that he is among those who are interested in his welfare.*

The admission procedure may be an everyday occurrence for you, but often it is a life crisis for the patient.

Usually newly admitted patients are in a tempest of unsettled thoughts and feelings, and it is a fair guess that they are thinking of things sad and confused. Touching reminiscences fill their soul; they ponder on the illness and its outcome; they feel insecure in an unfamiliar environment. Furthermore, they are out of sorts with the world and transfer antagonistic feelings to the institution.

The feeling state of the patient is of primary importance. The patient suffering from a mental illness may not appear to comprehend as clearly as his neighbor who is being admitted for a major operation, but he has the same feelings and, if anything, these are intensified. These feeling states need expert understanding and wise handling; nursing care begins with the very first contact with the patient.

Meeting the Patient.—From the very beginning know the patient's name; and, if at all possible, have this information at the first moment of contact. A patient's name is important and distinctive to him. To be called by his own name, especially at the very first meeting, increases his feeling of value and personal worth. To know the patient's name is one of the first requisites in successful interpersonal relationships.

Here is the story of a man who calls himself "Submucous Resection."

Mr. A. went to the admission desk of a general hospital, gave his name and said he was Dr. S.'s patient. The clerk answered, "Yes, you are the submucous resection." This clerk called another clerk saying, "Here is Dr. S.'s submucous resection." The second clerk asked many personal questions and then without looking up said, "Go through the door and up the stairs." Mr. A. did not know which door but proceeded to the nearest one. He did not find a stairway. He went through another door and found himself in a private office. He returned to the clerk for help. Evidently she had made a mistake, for this time she said, "Go up the stairs and through the door." He reached his destination and was greeted with, "Oh, yes, you are the submucous resection."

The preceding account is one of indifference to the patient's feelings. No one would blame the clerk for having made a mistake; but she did not observe the patient's dilemma. Her facial expression may have been kind, but from the patient's account it did not invite approach, and not looking at the patient when she gave information removed an opportunity to return a look and make the patient *feel* a welcome (transfer of feeling tones). Then imagine his embarrassment when he asked to have the information repeated; think how he must have felt when, reaching the section of the hospital that was to be his home for the next few days, he was called "The Submucous Resection." This makes one think of Indian tales about Pain-in-the-Neck, Little-Man-with-the-Hare-Lip, or Chief Broken-Nose.

In dealing with the patient, points of contact should be studied. Salutations such as "good afternoon" do not mean much in themselves, but from the human inflection in the voice and the general manner each party is able to estimate the interest and existing mood of the other. These greetings melt or freeze the social ice.

A smile can reassure a patient, but the only effective smile comes from a sincere interest in the patient and pleasure in administering care. One is not successful just because of a resolution to smile. There are smiles of pleasure, but there are also smiles of amusement, ridicule, contempt, despair, and there are smiles that are cold and uncertain.

The social custom of shaking hands has value. A patient's fear and lack of ease can be perceived in the speed with which he extends or withdraws his hand; his general interest and vigor for

life can be estimated in the way he grasps the hand; and a warm clasp of your hand can tell the patient he has reached a place of security and comfort (transfer of feeling tones).

Newly admitted patients ask the same questions. Some of these are: Where am I? Why am I here? How long shall I have to stay? Why should I go to bed? What are visiting days? Shall I be allowed to have visitors? Shall I receive mail? Am I allowed to write letters? Who has my money? Where is my jewelry? Where are my clothes? How shall I get cigarettes? May I have the daily newspaper, new books? May I go to church, out of doors? In general, the questions relate to life in the hospital.

Some hospitals have this information available to the patient in pamphlet or letter form, in which case it is better to refer the patient to this written material or read it to him. In any event be familiar with such information. Otherwise prepare yourself with satisfactory answers to these questions—satisfactory to the patient and to the hospital.

Suggestions for Reducing Emotional Distress.—The following suggestions are given as a nucleus around which to build ideas.

1. Extend a gracious welcome.
2. Demonstrate the readiness of the hospital and personnel to receive the patient.
3. Make the patient aware of the absence of hurry.
4. Provide information on the location and care of valuables and clothing.
5. Introduce the patient to neighbors and personnel.
6. Inform the patient concerning the people with whom he will deal; *e.g.*, if the laboratory technician is to do something for the patient, give the technician's name, his general function, and describe him so that if he arrives when you are not at hand to provide an introduction the patient will know what it is all about.
7. Supply information about the place—location of the dining room, bathroom, etc.
8. See that the bathrobe and slippers are at hand.
9. Give some instruction regarding immediate ward routines and activities.
10. Do not leave the patient alone until he has a feeling of security in his new surroundings.
11. Be dependable, especially in all details.

The Spirit of the Hospital.—A patient's approval or disapproval of a hospital is based on his first contacts, and he will remember the spirit of the institution after his stay is forgotten. Your attitude of welcome—words that are proper to the occasion, eyes that show recognition, a voice that is modulated and vibrant, a spirit that encourages and supports, a manner that transmits confidence yet invites sympathy (transfer of feeling tones)—is very, very important to the patient's emotional comfort.

The admission procedure is the first adjustment between the patient and the hospital, and it is a time when you and the patient measure each other. An attitude that radiates kindliness, fair dealing, and interest is felt by the patient, but if unfavorable feeling tones are produced within the patient they remain unchanged indefinitely. The patient's reception by the hospital greatly influences the ease or difficulty of subsequent treatment and care.

Arouse Interest.—The goal for all positive action is to arouse interest in the patient.

Motivation of Behavior.—You studied the motivation of behavior in your psychology course, and you have used the principles effectively with patients on the medical and surgical wards. In the hospital for the mentally ill you use the same methods but you meet a new practical problem, namely, you cannot see the motivation of behavior function in line with your effort *until the patient is getting better.*

In mental illness the basic factors on which motivation of behavior is centered and built are changed. The patients lack drive, goals, desire, purpose. It seems impossible to arouse interest in a patient when he is absolutely lacking in interest and antagonistic to all positive potentials, to touch altruism when the person thinks only of himself, or to appeal to pride when there is no pride. The tremendous initial task is to get the patient to do *anything*. Often the labor is not a matter of directing activity but of selecting and initiating activity. The preliminary step is to make activity necessary.

The particular difficulty in motivating the behavior of those who are mentally ill is seen most clearly with the delirious, confused type of behavior. You are at a loss to make contact, there is no starting point, there is nothing on which to depend. You feel defeated at the very beginning. You find the same thing in

psychoneurotic behavior, except that here there is a natural tendency to be annoyed with the patient because the rational behavior makes it hard to appreciate that behavior mechanisms are not working in a state of health.

The nursing obligation is discouraging; the task is not hopeless, however, especially when the patient has not been ill too long or normal habits of thinking and feeling are not destroyed or too badly disintegrated. Regardless of the patient's behavior, keep working toward normal potentials whether you see results or not. You will rarely know at what particular moment your effort in behalf of the patient is first effective. Your chief difficulty is the fact that so much of the time you work in the dark and have to keep fighting to secure satisfaction and retain hope.

Primary Principle.—In order to arouse interest you must have a sincere interest in the patient. This is of value because of the transfer of feeling tones. Often when a patient is very ill the only effective contact is through the transfer of feeling tones that become a stimulus for activity. At this point there is a noticeable difference between the patient who is mentally ill and those on the medical or surgical ward, namely, *you* may have to select, initiate, and direct the activity.

The following are suggested as possibilities for stimulating interest:

1. Security. Provide a general ward atmosphere of peace and have the patient appreciate that he is among those interested in his welfare; this establishes an essential setting.
2. Beauty. Pay attention to color, order, line, form; these influence feeling states and are a part of the desirable setting.
3. Recognition. Give personal, individual attention and plenty of it.
4. Prestige. Place the patient in group activities where he can win social approval and experience personal worth.
5. Curiosity. Introduce novel situations, variations in procedure, the element of expectation and surprise.
6. Obstacles. There is stimulation in overcoming obstacles; important points are: Be hypersensitive regarding obstacles; appreciate which obstacles are possible and which impossible for this particular patient to overcome; prevent or help the patient meet impossible obstacles; place possible

obstacles in the way and see that the patient experiences success.

7. Sentiment. Appeal to pride, pleasure, anticipation, desire, hope, altruism.
8. Creation. Encourage wholesome imagination, original work, productivity.
9. Practical aspects. Try to impress the patient with the importance of economy, utility.
10. Specific challenges. Challenge the patient to improve a method, increase speed, and enter into competition.
11. Repetition. Frequent repetition may establish an urge.
12. Worth-while goals. Pay attention to matters that relate to accomplishment and to helping others; these provide depth in feeling.

Ponder on these possibilities, particularly as you use them with the patient. In all dealings with the patient be scrupulously honest and fair. Never make a guess at something just to produce a certain effect for the moment; for example, do not arouse a specific hope unless you are reiterating something the physician has told the patient or saying something you know is true. Be especially careful in this regard, for one flip, glib, thoughtless remark can ruin the therapeutic relationship with the patient. Security through dependability is essential.

Study methods for the motivation of behavior in relation to the patient when you are with him: his past—his habits and attitudes, custom, point of view, ambitions, pride, jealousy, hatred; his illness; his personal needs for healthful living as prescribed and suggested by the physician. Use your effort as material for consultation with the physician.

Important Nurse Qualities.

1. Be friendly.
2. Be dependable.
3. Accept responsibility.
4. Apply self-discipline.
5. Be versatile.
6. Exercise the golden rule.

Be Friendly.—Friendliness is a warm, live personal bond that comes from interest and understanding. Much more is needed than a big heart, a dovelike disposition, and benevolent words.

Friendliness requires that the patient-nurse relationship be a partnership affair, something that is shared. At first it seems queer to think of sharing anything with some of the patients, as their world often appears to be different from yours, but it is your duty to find out something about their world. Underneath the surface all patients are simple-hearted, amicable, and desperately in need of friendliness.

Friendliness does not call for familiarity. In fact, familiarity destroys a positive influence over a patient. You lose a necessary objective point of view, and familiarity concerning the intimate details of the patient's illness obliges him to forfeit a security possible only in a professional relationship. From an emotional point of view, to be too close is to be feared.

In friendly relations that develop toward intimacy, keep in mind the fact that the stimulus for the patient's emotions resides in the illness situation. Remember, also, that your attractiveness depends on the warped judgment of a sick person and may be related to a uniform, gratitude, or a temporary need. A third point to keep in mind is that the nursing uniform is as much a protection to the patient as to you.

Be Dependable.—When you tell a patient that you will see that a certain message is delivered or that the daily newspaper will be ordered, see that these pledges are carried out. Never offer a promise you are not able to make good. Dependability is a basic factor in all effective nursing and especially so in psychiatric nursing.

When a patient senses dependability in you, he finds something to grasp that is solid and trustworthy. In turn, he experiences confidence and security. Your dependability has the same effect on the patient as does the motor in an automobile on the driver; behind the wheel a driver feels strong and secure because he takes unto himself some of the power of the engine.

From an emotional point of view it is important that dependability not become an expression of constant control. During a period of uncertainty the patient may receive great assistance through a proper masterfulness on your part, but as his uncertainty lessens the evidence of mastery may not be needed or welcome. You should not feed a patient if to help him feed himself is what is needed. Knowing when a situation is handled best through obvious power and skill, when to withdraw tactfully

and how subtly to transfer the power of independence to the patient are fine points in the changing of moods and attitudes.

Accept Responsibility.—Adjusting the environment to the patient's needs is a nursing duty. Very often it is not that you do a particular thing but that you appreciate a need and accept a responsibility concerning the matter that is important.

A very trying situation for patients is to have nurses evade an issue or "pass the buck." If a patient is kept guessing and wondering (that is, if his thoughts cannot be terminated or concluded) he suffers strain, and unrest results.

Mrs. S. had been a patient whose happiness was destroyed by the delusion that everyone was against her. After having been home on parole she returned to the hospital for examinations. First she went to the eye outpatient department; there her glasses were to be changed and mailed to her home. Then she went to the psychiatric outpatient department and from there was readmitted. The next day she wanted to read. It should have been a simple matter either to have obtained the glasses from the eye department [same hospital] or the information that they had already been sent home; but the matter went on for days before the patient was given a definite answer. [By that time the glasses had been sent home.]

The lack of care in the above situation increased the very factor that had caused the patient to be admitted to the hospital. Furthermore, it illustrates what is meant by the term "letting the person down." You cannot behave thus and hold confidence and respect.

Nursing responsibility continues until a need is met. For example, if Mrs. B. has a rash on her hand for which the physician orders a special soap, it may not be enough to give Mrs. B. correct directions; you may have to see today, tomorrow, and every day that she uses the soap and that she keeps it away from other soaps.

Often it is not enough to tell a patient what he is supposed to do, *e.g.*, get dressed. Frequently the patient accepts what is said and seems to understand, but later on you will find that he has not made a move. Memory may be poor, there may be a break between thinking and motor activity, or the person may be preoccupied and when left alone is unable to direct energy toward a particular need.

Do not ask a sick patient if he wants a bath. It is not sound psychiatric nursing care to put the responsibility on the patient. Either give the bath or do not say anything about it.

If a patient likes weak green tea, he should receive weak green tea and should not have to ask for it a second time (you should increase feelings of importance). You do not carry tea balls in your pocket, neither do you prepare the tea, but to see that the matter receives the proper attention is a nursing responsibility.

At a hospital party, Mr. N. sat all evening on the window sill with his right leg crossed over the left. As he left his place of evident security, one could see why he had not mingled with the others; there was a hole in the left leg of his pants just above the knee.

It was the nurse's responsibility to have the matter of the torn trousers attended to, and if absolutely necessary (which is not likely) it was her place to have put in a temporary patch. Sewing is not a nursing activity, but the use of intelligence is. Judgment is part of intelligence, and some situations call for inconsistencies. For this patient, the social gathering was a *treatment* to help him overcome shyness. The nursing responsibility was to make sure that the patient was ready to receive the treatment.

Apply Self-discipline.—Self-discipline is necessary for successful nursing, particularly in regard to the freedom of your own behavior, irritation from noise, and outward expressions of inward tensions.

With the exception of carrying out specific orders, psychiatric nursing is a kind of listening—a function of the brain. In all matters of interpersonal relationships, until you know something about the patient as a person,

1. Hold back all direct contradiction to the patient's sentiments.
2. Give intensive thought to your own positive assertions.
3. Guard your tongue.
4. Reserve judgments.
5. Proceed cautiously on a trial-and-error basis.
6. Utilize reasoning and judgment to practical ends.

Never act without thought. Weigh implications and contemplate on probabilities and possibilities. Making a mistake in interpersonal relationships is not so great a nursing delinquency as a failure to think and plan beforehand and to reflect afterward.

Unless you are keenly alert and on guard, the conduct of your affairs away from the patient influences your behavior in his presence. Your feelings are transferred to the patient and become a part of his feelings. Even your intention is sensed and carries with it as much power of pleasure or pain as what you do or say (transfer of feeling tones).

Either directly, through conversation, or indirectly, through attitudes, the patient is apt to sense your feeling of uneasiness over an impending examination, your worry when a near relative is ill, your gamut of feelings experienced in love affairs, even your feelings of frustration when you look out of doors in the spring and long to be free.

Theoretically none of these feeling states should be sensible to the patient, but they are unless the matter is given special attention. Nursing, too, is a profession where the "show must go on."

People look upon a hospital as a "zone of quiet"; in a psychiatric hospital, however, noise in itself is relatively unimportant.

When a patient becomes noisy and shouts, an inexperienced nurse is inclined to think that this is a menacing situation and that something should be done about it immediately. Weigh the situation: Is there pain? Is it day or night? How many people are disturbed by the noise? Is general activity increased? What is the history regarding noise? Will the noise last only a short time, after which the patient is relieved, or is it the beginning of excitement that will steadily increase and get out of control? Is it simply this particular patient's way of expressing aggression?

"Tongue lashings" are usually given loudly and vehemently and seem quite alarming, especially to a stranger. However, you will learn that often this is an expression (temporary) of inner emotional pressure and that aggression pressed out through the voice box is less to be dreaded than that which comes out through the feet, the hands, the teeth.

Sometimes it is wise to put noisy patients together; they seem to have a wholesome restraining influence on each other. Also, it helps to put a patient on a porch (seeing to it that he is sufficiently warm); it appears to be not nearly so satisfying to scream into the great outdoors as in a small room where the sound reverberates and builds up to tremendous volume. The best solution is to take the patient out of doors on the hospital grounds. It is unfortunate if the hospital adjoins private property; neighbors

object to the noise and are convinced that the patient is being abused; and, because of public opinion, there is a tendency for the hospital to keep the noise inside. Also, the great difficulty involved in getting the patient out of doors makes it easy for workers to prefer not to press this particular procedure.

Be Versatile.—Among your patients, you take care of the butcher, the baker, the candlestick maker. You have those with much education, with little education. You cope with whims, fancies, fads, eccentricities. You care for dreamers, jokers, bores, shylocks, family despots, industrial giants, social lions, angelic souls, abandoned creatures. A decided aid is to be yourself versatile in interests and in effort.

A great deal is expected of you; but what a challenge! It is only by digesting life experiences that come to you and to others and by storing up associations through a wide range of intellectual interests that you can perceive mental and emotional meeting places for you and your patients and give them the understanding they need.

Exercise the Golden Rule.—Each morning on going on duty, say to yourself: "Today, I shall do for my patients as I would like them to do for me, providing I were in their place." This is not a simple precept. It calls for imagination and deliberate mental effort. It requires the utilization of knowledge of the patient as a person: his tastes and sense of values, his interests and desires, his problems, his needs, his resources, his hopes, his fears, his dreams, and how these affect his perspective of the situation at hand. Because you like olives is no assurance that your patient likes them.

Some "Do Nots."

1. Do not lie or deceive.
2. Do not give thoughtless advice.
3. Do not injure a patient's self-respect.
4. Do not make an open issue.
5. Do not attack an incorrect point of view.

Do Not Lie or Deceive.—The patient is endeavoring to find stability and solidity and to gain faith in himself and others. It is more than likely that previous to admission he was deceived by one or several people, particularly in relation to the hospitalization; and almost the first test the patient will give you is an opportunity to evade and even tell or imply a falsehood.

The greatest problem is answering questions concerning his illness. The newly admitted patient will ask where he is and why. If the hospital does not give you specific answers to such questions, ask for such help from your instructor or head nurse. The answers to such questions are very important in relation to the initial nursing objective—gaining rapport—and to objectives in remedial approach.

If behavior is hateful and nasty, it is not condemned or looked upon with contempt, but there is no reason to pretend the behavior is anything but what it is. If ideas are peculiar, it is all right to say so (if cornered) or that you do not see the matter in the same way. If the patient writes reams of letters to you and you do not read them, say so. Delicacy is required, but to lie or deceive is a serious nursing error.

The patient seeks understanding. To say you understand when you do not is a grave matter. If you understand, you will not have to put it into words for the patient is watching with an eagle eye for facial expressions, mannerisms, attitudes that tell. In such matters the patient is probably more acute than yourself.

When a patient knows a nurse has lied to him, the initial objective—to gain rapport—is placed out of reach; and the very foundation upon which nursing care would be built is destroyed, possibly beyond repair.

Do Not Give Thoughtless Advice.—It is silly to advise the nervous patient not to worry, the depressed patient to cheer up, or to tell any patient to “snap out of it” or that tomorrow he will feel better. Such methods are logically incorrect and not only futile but objectionable, for they sustain and promote negative attitudes.

Never give advice of any kind to any patient regarding personal matters that relate to a deep level of feeling, unless specifically instructed by the patient’s physician or the head nurse.

Do Not Injure a Patient’s Self-respect.—The patient’s regard of himself directly influences his mood. Watch that you never unnecessarily deprecate a patient’s value, usefulness, or importance.

Many patients are distressed for weeks because someone says something that cheapens personal worth. When Mrs. A. cries for days because a nurse says she is insincere and brings this to the surface every now and then and cries some more, it is a symptom of illness; nevertheless, it is a needless hurt and an unnecessary

block in gaining rapport. It definitely deepens negative emotional reactions.

In the course of treatment a patient may have to face the fact that he possesses undesirable personal characteristics. However, the undesirable characteristic is first established as a fact, then therapeutic measures are carried out, under direction and not before the time when emotionally the patient can cope with the hurt and unhappiness that such revelations bring.

Do Not Make an Open Issue.—In patient-nurse relationships be keen enough to sense when the situation is unnecessarily beginning to occasion antagonisms in the patient. If possible, withdraw for the time being; go do something for another patient. To push antagonisms to an open issue means abject surrender for you. It also tends to arouse anger, resentment, bitterness, defiance, revenge in the patient, and to bring about assaultive, combative behavior.

Do Not Attack an Incorrect Point of View.—Frequently a patient's point of view is warped, distorted, biased, incorrect—even when the intellectual faculties work clearly. If the point of view can be changed, this will take place during the program of treatment and care, but do not attempt to bring about a sudden change in any single incorrect point of view by open attack. A direct attack, or even a challenge, noticeably deepens negative reactions.

These false points of view are dealt with realistically. They are not accepted as correct or sound; they are not encouraged or fostered. Be careful not to let the patient lead you on to get your point of view. When you find your opinions are being drawn out and you feel insecure regarding the wisdom of your remarks, close the matter by saying graciously something to the effect that you are not sufficiently informed concerning details.

Patient Rights.—In interpersonal relationships, the patient, too, has rights. Some of these have to do with the following points: In the hospital a social situation exists. The patient should be called by his right name and should be acquainted with hospital routine and language. His rights as a person should be respected, and, so far as possible, he should be allowed to be himself.

Accept the Existence of a Social Situation.—In all interpersonal relationships, a fine regard for the rights of the patient is necessary. Too often nurses go into the sick room with an I-am-monarch-of-all-I-survey attitude. You are not alone; the patient's presence

creates a social situation. To live peacefully the patient, too, must receive emotional nourishment. The qualities of justice, honesty, friendliness, and generosity should be apparent.

In all patient-nurse relationships you function in a social unit. The social situation is unusual, however, in that the patient's endurance may be reduced and he may not be equal to his part in social reciprocity. More understanding and greater effort are required of you, but the essence remains unchanged.

Call the Patient by His Right Name.—In hospitals for the mentally ill, frequently one hears a middle-aged woman called "Mary," or an elderly person "Grandma" or even worse, "Granny." The behavior of a person often leads one to think he is simple and childish; however, nursing care is brought up toward a normal person's state of health, and men or women of fifty should be accorded the dignity of their years. To call a patient by his proper name is a small way to increase wholesome self-esteem and a simple way to influence moods and attitudes.

Acquaint the Patient with Hospital Routines and Language.—Information on hospital routines and language will reduce a patient's feeling of fear. An omission of breakfast without an adequate explanation may cause much discomfort; an enema for the first time in a person's life can be a frightening experience. Such expressions as "spinal puncture," "O.T.," "staff," "parole," "psychometric" can fill a new patient with alarm.

Besides having information on the hospital routines and language, the patient should know what the hospital expects of him, why he is in the hospital to begin with, why he is on a particular ward, and what changes in him are necessary to make him eligible for promotions such as ground parole.

Some of these situations are delicate to handle. Your first responsibility is to appreciate a need for such information and then be prepared to meet the need. If you do not have the necessary information at hand when you want it, get it immediately—or shortly after from the head nurse or instructor, and then do not forget to pass it on to the patient.

Respect the Patient as a Person. Many patients, quite aside from the symptoms of illness, have trying characteristics and habits that present real problems in interpersonal relationships. Often there are disagreeable, weak, ugly traits imbedded in the character

and personality. Even those who possess a cultivated mind and innate nobility of soul have peculiarities and stormy spirits.

Some patients are definitely unattractive. There are mouths that droop like weeping willows, necks that look like hen's legs, and walks that make one think of hookworm. There are attitudes that grab, suffocate, and crush. There is the human radio, the universal genius, the gum-chewing champion, and the person who begins a simple story that grows into a Canterbury Tale modernized with you-knows, okays, whatzits and whosezits. There are those who are indifferent, like an ox. And perhaps the most trying of all is the even-tempered, uncompromising, unproductive type—adjectives one might employ in describing the sturdy and faithful ass.

In health many patients are dominant, aggressive individuals; in illness they cannot be happy in submission. In the hospital, where female nurses predominate, some men find it difficult to accept any authority in women. Men who cry are not necessarily sissies. People who live rich, full lives and who have quick, warm emotions shed tears easily; this has been said of George Washington, Oliver Cromwell, Alexander the Great, William Pitt. Some patients like to annoy and trick. Many of these characteristics and habits are mere bubbles in the entire course of events and, when viewed in the proper perspective, take a place of little or no importance.

The patient's individuality is a precious and prized possession. You have no right to try to change him more to your liking, to do for him only what is necessary because he falls short of your opinion of a "good" patient, or to attempt to fit him into a pre-conceived rigid scheme.

It is your responsibility to develop within yourself attitudes that respect the patient as a person. The longer you deal with patients the more you see them as a fair combination of what is pleasant and unpleasant, and single personal characteristics do not stand out as factors to be praised or condemned but as appropriate to their possessor. In your thoughts these individual characteristics and peculiarities become analogous to hair on the chest or a mole on the back.

Let the Patient Be Himself. A person would rather die than not be allowed to be himself. Patrick Henry's "Give me liberty or give me death" was not a rhetorical flourish but a cry for individual

freedom and an announcement of a vital choice between two mutually exclusive basic conceptions of life.

Miss A., a graduate nurse, is conscientious; her nursing techniques are good; everything ordered for the treatment of the illness is carried out to the letter; she works with great intensity. She is respected for these fine qualities. But she is oblivious to the personality and emotional needs of her patients. She is not possessed of her nursing techniques; she merely possesses them and wears them like an indispensable defensive arm. Her spirit in no way denotes a sympathy of mind with mind; she hurts the patient's feelings and, without appreciating it, disturbs his complacency. The patient appreciates her mastery of techniques but feels overmastered, circumscribed, shut in, humbled. He feels strained, oppressed, bound down by string and pegs like Gulliver.

Sometimes a physician asks something of a patient and when the patient does not reply immediately the attending nurse says, "This is the doctor, answer him." Here, the nurse should not say anything. The physician seeks a spontaneous reaction, and such a remark changes the patient's attention, interferes with his sense of freedom, adds to his confusion.

In illness a patient's strength is reduced and his security threatened; it is especially important to have him experience a sense of personal freedom. He should have freedom to feel, to think, and to view things in his own way. If his point of view needs to be changed, that is part of a prescribed therapeutic plan. If the patient must be watched and guided, it should not be too obvious; do not make him feel under supervision like a kind of convict.

Patient Needs.—The following points are presented to draw attention to patient needs:

1. Adjust to the patient.
2. Be subordinate at the right time.
3. Learn to compromise.
4. Attend to trifles.
5. Anticipate emotional needs.
6. Overlook selfishness.
7. Look for points in common.
8. Search for an interest.
9. Plan conversation.
10. Help the patient build faith in himself.
11. Introduce beauty.

Adjust to the Patient.—In so far as it is proper and wise, adjust the environment to the patient's capacity and level of understanding. Study the patient as a person—his home life, his education, his tastes, his habits, his sense of values—so that in conversation and understanding you can offer something that he recognizes and picks out as his own. He feels protected and secure mostly through things that are familiar to him.

When necessary adjust hospital routines to meet individual needs. Necessary changes are an expected part of the entire program, especially until the patient is equal to accepting his obligations and responsibilities in the total situation; in the meantime, however, he is not allowed to presume on his status as a patient and make himself obnoxious to others or a disorganizing influence in the ward.

Be Subordinate at the Right Time.—If the patient-nurse relationship is successful from an emotional point of view, you will be subordinate to the patient some of the time.

You are dominant in anything that pertains to physicians' orders. You maintain a dominance through skill, flawless serenity, personal integrity, dependability. However, much of psychiatric nursing consists in dealing with situations that relate wholly to human intercourse, and these situations are governed by cooperation and reciprocity. Some of the time the patient's opinions should triumph.

In patient-nurse competitive-game situations, the subordinate place you hold when you lose is fair and wholesome. To be effective, manage to leave the patient at a time when emotionally he is dominant; that is, when he is the center of interest. This increases a feeling of importance and pleasure in your company — strengthens rapport, lessens negative reactions, stimulates wholesome reactions.

A patient who was ill with an organic illness had eighteen nurses in twelve weeks. One night nurse stayed with him during the entire time. The difficulty was that the patient's ideas on temperature were incorrect. This seems such a small matter, yet to wash his hands, to give a bath, even to regulate the temperature of the room made every minute of the time problematic.

In the beginning, the nurse who remained with the patient carried several basins of water for one washing of the hands. This was extremely trying and consumed energy, but not nearly as much (for either the

patient or the nurse) as having the patient upset about it. Much of the patient's behavior was caused by anxiety, and when he appreciated that the nurse was doing her best to cooperate with him in his distressed feelings the problem ended *for this particular nurse.*

Carrying water several times for one washing of the hands required moments of definite submission. To an onlooker it might appear as servility, and it could be. However, if such an activity is carried out from an intellectual appreciation of doing something a certain way to bring about preconceived results, pleasure in understanding is experienced and dignity is maintained. Such behavior is conscious, purposeful control and regulation of a situation.

A chess player frequently opens the game by sacrificing a pawn or a piece, or several successively, for the sake of an advantage in position. Business usually takes the stand that the customer is always right. Voltaire was so clever that he could make a blunder on purpose, and Socrates persistently bore insult from others to make personal relationships smoother.

Sometimes to achieve ultimate and complete success it is necessary to accept and bow humbly in certain unsatisfactory instances; throughout such situations, however, you must know what you are doing and why or else you lose control and resign the leadership to the other personality, the patient. This kind of nursing calls for composure, insight, fortitude, but it is the same kind of silent patience, depth in judgment, and strength in courage that is required for successful living.

Learn to Compromise. -Compromise is an adjustment all psychiatric nurses have to make, particularly regarding routines, in which duties are defined, details clarified and simplified, and the need for thought and choice are reduced. Following routines gives a sense of security and a feeling of pleasure and relief to the nurse.

In psychiatry you do not carry out routines by habit; you consider the need and the opportunity. Why try all night to get a patient asleep and then wake him at 5 A.M. to get ready for breakfast at 7:30 A.M.? Why force a patient who has combative tendencies to take a bath at exactly 9 A.M. if at that time the tension in his muscles, eyes, and voice tells you that he is all set to "blow up"? Why race a frightened patient, on admission through an unfamiliar course of action?

Compromise requires a sensitivity to the patient's emotional needs, a willingness to see with a long-range and a wide vision, and a regard for, and devotion to, the patient's interests. It is through compromise that hospital routines become less evident and that the patient gains a greater sense of being a person among persons.

Even in the spirit in which routines are carried out a compromise for the nursing personnel is involved. Routines are necessary to prevent chaos; however, the administration of routines is delicately and skillfully devised. The objective is to have the patient do what is required, at the desired time, and without a feeling of regimentation. This is another fine point in the art of psychiatric nursing which requires unusual mental acuity.

Conflicts arise between your wishes and those of the patient. When the matter is unimportant so far as treatment is concerned, a resort to compromise gives the patient pleasure in reciprocity and prevents him from feeling at a disadvantage.

Attend to Trifles.—There is great peace for the patient when you do simple things faithfully and well. The greatest enjoyment in living comes from small ordinary attentions—a cold drink offered on a hot day, an unexpected kiss, a smile from a stranger, an extra dime. In illness, crises are met with fortitude but trifling occurrences throw a patient into a frenzy and exhaust him. Attention to every detail, no matter how humble, is indispensable and therefore dignified.

While bathing Mrs. W., I noticed that she kept her eyes focused on the wall nearby. The point of interest was a small spot of dried blood. When Mrs. W.'s attention was elsewhere, I removed the spot, but the patient knew what I had done and said, "What was that? Do you know, that thing has been bothering me ever since I have been here. It looked like a bug and I was always afraid it would crawl into bed with me sometime when I was asleep."¹

Seeds of joy reside in trivialities. It is the small sweet courtesies of life that make it smooth. Usually, the trifles that give patients so much comfort demand thoughtfulness, gentleness, and skill on the part of the nurse. Sensitivity to emotional needs and executive capacity are more important considerations than expenditure of time and energy.

¹ Render, Helena W. "The Understanding Heart," *The American Journal of Nursing*, December 1937, pp. 1356-59.

Anticipate Emotional Needs. -You should perceive emotional discomfort in a patient before he has time to express it in words. Also, your ideas on comfort and how to bring it about should be beyond the conception of the patient. When a patient asks for this and that he is not demanding service; he is seeking comfort.

A patient should not have to solicit comfort. Does he have to say he has wet the bed? Or ask the names of physicians and workers? When a patient is being interviewed by a physician and tears come streaming down his cheeks, is a handkerchief provided? When the forgetful patient lays down his glasses, are they handed to him just before he needs them? And is such attention withheld from the patient who is independent and not forgetful?

On the psychiatric ward, such occurrences increase and take on a more personal nature. Mr. A. becomes upset when airplanes are mentioned, Mrs. B. bursts into tears when she hears the Bach-Gounod "Ave Maria," Miss C. is afraid of broken glass, Mrs. D. shudders at the sight of red, and Mrs. E. cannot stand the name of Mary. *Until the proper stage in treatment is reached,* the patient is shielded from specific situations that incite emotional distress.

Anticipation of another's need is an energetic process. When you assist a surgeon with a dressing you anticipate his needs. The first time you may not know his plan of action, but you soon pride yourself on being mentally just one step ahead of the requirement. The patient needs the same kind of attention. It is harder, because there is no routine and you have to know the patient as a person. You get your cue from his countenance, his attitude, his posture, his breathing, the movements of his hands, the expression in his eyes.

Overlook Selfishness. Most patients are self-centered. The outward expression of this self-interest, behavior, differs greatly; if viewed objectively, however, it can be seen as a defense against insecurity, fear, and anxiety.

The behavior of the average woman convalescing from a physical illness is an example of selfishness. At times her selfishness is unbearable, but she has reasons to be selfish. She was in a position of danger, but now she experiences a triumphant sense of security and the pleasure of escape following peril that fills her entire being. Things of a serious nature do not affect her; no business is as important as her own. In the sick room she is the supreme object. She revels in sympathy, and at times she becomes

charming and delightful from attention. She is selfish, but her selfishness is really a duty and has a light and amusing aspect.

When the expression of selfishness is directed outward and the rights of others are disregarded, the person is not pleasant to have around. His selfishness causes him to clutch at the other fellow, to plow ahead making the other person submit, or else he has a dominating, aggressive quality that overrides. Such an individual is especially unreasonable. He is callous and blind to the way he trespasses on other people's needs. In interpersonal relationships he is a cheat, but one can feel sorry because he cheats himself—his own behavior prevents people from giving him the affection and support he needs.

The patient on the psychiatric ward is decidedly egocentric, but in general his selfishness shows itself in a different way. It is usually directed inward and destroys the individual himself. To those around him there is a goading quality to this kind of selfishness, and it, too, is not pleasant to deal with. Sometimes, especially when one knows the relatives, one is inclined to think that the ruthless selfishness of the patient is due in part to the ruthless selfishness of the people with whom he had to live.

If selfishness of a patient has a dominating, aggressive quality, it is your responsibility to protect other patients. Otherwise, overlook the associated disagreeable, irritating behavior; regard it as a symptom or the expression of an effort to meet a psychological need.

Look for Points in Common.—The interests you have in common with the patient help to establish sympathy, reciprocation, interdependence; they provide a meeting place for thought and discussion and reduce the patient's feeling of isolation. They become bridges of confidence.

The point at which your interests meet may be the exclusive blue glass of the Beacon Hill section of Boston, the elaborately carved and beautifully colored massive doors to the Legislative Chamber of the Nebraska State Capitol at Lincoln, a dinner at Fishermen's Wharf in San Francisco, horseback riding along Virginia's picturesque bridle paths, or the Aztec ruins of New Mexico. It may be a person, a seam, a cake, a clove hitch, baseball, bulldogs, Buetouche oysters, Wisconsin cheese, advertising circulars, the dairy character of a cow, or Brahms' Piano Concerto in B Flat Major.

The most effective point in common is the patient's interest of the moment. Awareness of this provides a constant opportunity for gaining rapport, for being subordinate at the right time, for increasing the patient's wholesome feeling of importance, but at the same time it is the most difficult to make use of.

When a patient mentions that her niece plays the Chopin Waltz in D Major ("minute" waltz) in a minute and a half, the natural reaction is to show superior knowledge by drawing attention to the idea that speed is not as difficult to master as the waltz rhythm. When a patient tells with pride of her two-year-old Mary's attainment in vocabulary, the natural immediate reaction is to bring into the conversation your superior niece who at the same age is using many conjunctions. Without thought, such interpersonal relationships become an "I for an I." This is an example of changing your own natural reaction, mentioned previously.

Common interests do not always have to be put into words. In walking down the street you may meet a stranger, and yet something within you responds to that person. Your sincere interest in the patient's welfare will have the same effect on him. It is communicated to him and instantly caught by him (transfer of feeling tones); he understands that you and he have the same thing at heart and in your minds.

For emotional comfort, there needs to be a successful meeting of minds. The patient cannot feel an emotional harmony if you are each thinking of your own affairs.

Search for an Interest.—Interest motivates the patient to think and act in relation to reality, thereby redirecting energy from attention to symptoms into healthy channels. In observing a patient, watch closely for moments when he pays attention.

To find potential interests, think of the patient as a person—his education, his life experiences, and particularly the things he likes or enjoys. These make good starting points. If Mr. A. used to like Dickens, which work was his favorite? Read episodes. If Mrs. B. likes to wear blue, pick out a blue dress for special occasions—a social dance, an important (important emotionally to the patient) visitor. If Mr. B. particularly enjoys Bach's Toccata and Fugue in D Minor for Organ, make it possible for him to hear it now and then. Furthermore, the very fact that you are sufficiently interested to remember these personal items will, in itself, stimulate interest.

Plan Conversation. During conversation you bring forth attitudes and thoughts associated with the patient's previous experiences. Plan conversation. The plan must be elastic, as you cannot use prepared thoughts on conversation any more than prepared answers to examination questions. In planning conversation it is important to appreciate when conversation is out of place, what subjects are "dangerous" to the particular patient at hand, and the therapeutic value in intelligent silence and attentive listening.

Unwise conversation can be damaging in its effect. Both Charles Dickens and Edmund Burke express the idea that a very great part of the mischiefs that vex the world arise from words. It is through conversation that you make patients comfortable in the most frequent and subtle ways or uncomfortable in the most repeated and innocent ways.

The newly admitted patient is fearful and views the entire situation with suspicion. Any conversation should be especially guarded because, without knowing it, you may prevent or destroy confidence in the hospital and its workers. The patient on the "disturbed" ward is in a state of emotional turmoil. The physician knows what to say; the experienced nurse acquires some wisdom in this regard; the inexperienced nurse invariably says much too much.

Usually the young nurse lacks adequate grasp of reality, and anything said beyond what needs to be said is apt to be childish, superficial, even silly (not childish, superficial, or silly in itself but in relation to the need). In the beginning, the truly helpful contact with the patient comes less from words than from a sincere interest and affection as shown through the eyes, the voice, the smile, the touch (transfer of feeling tones).

Sometimes it takes quite a while to find suitable subjects. It is well to keep in mind some opening gambits on neutral topics—the weather, magazine covers, evening clothes. Be alert to realize when a supposedly "neutral" topic arouses too much emotion. The topic for a long conversation should waver until it rests on something directed by the patient. The tempo, too, depends on the patient.

Study the patient as a person. When you know that he has had a son killed in an airplane crash, be judicious in conversations about airplanes. When he is an immigrant who digs ditches for a

living, do not make him uncomfortable by attempting to discuss Diderot's paradox, Rousseau's treatise on the inequality of mankind, or Søren Kierkegaard's ideas on existential thinking; at the same time, realize that the ditchdigger may be educated and wise because of his age and experience.

Direct conversation into wholesome channels. Discussion of medical subjects in general and symptoms of illness in particular, of religion, politics, psychology, and philosophy are avoided. Do not ask questions that touch on deep levels of feeling, and try to recognize when deep levels of feeling are aroused.

Silence is an essential part of every conversation. It can produce acquiescence, push one to the wall, or have an aggressive quality that forces the other person to speak, but it can also tell the patient that you belong to him at least for the moment. A silence prompted by understanding has medicinal properties, especially for the newly admitted patient, the excited or disturbed patient, the patient in a continuous bath or wet-sheet pack.

Listening, too, has therapeutic value. The listener is an indispensable partner in any conversation. Successful listening draws the patient out of himself. In the beginning he often just talks; then, depending upon the emotional relationship with the listener (rapport), his inner self is unloosened. At first the talk may be uninteresting and loaded with hatred, bitterness, and revenge; but, more often than not, the better, sweeter self soon comes to the surface. If the patient tries to make a confidant of you, be sure to let the physician know. If patients make confidants of each other regarding their problems or illness, draw this to the physician's attention also. When patients release inner tension by talking to others, the physician may not obtain information that he needs for guiding treatment.

Many patients, if allowed free rein, will talk only about themselves and their symptoms. In such cases attentive listening for long periods is prohibited; but that is something which is included in the definite program of treatment and care. Probably you will have to tell such patients that you do not talk on such subjects because you do not understand enough to be of any real help, but each time refer the patient to his physician.

As you listen to a patient, you become less eager to match the patient's ideas with your own bigger and better ones, you realize that the patient's favorable qualities are nearer the surface than

you had supposed, and you learn a great deal about characteristic outlets to emotional states.

Help the Patient Build Faith in Himself.—Not to have faith in oneself fosters a tremendous sense of futility. In any illness a person's faith in himself is threatened, even though in health his will may be strong enough in most affairs of life. Deep down in their inner selves most people who are mentally ill are frightened, insecure, unhappy, even those (and perhaps especially those) whose overt behavior is aggressive, demanding, dominating. A controlling feature in nursing care is the creation of situations that provide wholesome feelings of importance. Make the patient feel as important as Aesop's fly when he sat on the axle of a chariot and said, "What a dust I do raise!"

The simplest and most effective way to make a patient feel important is through individual attention.

Several months following her discharge from the hospital, Mrs. C. returned to be sure that a certain nurse knew that she had initiated the first desire to live. The patient had been confused and disoriented. For several nights this particular nurse had spent all her spare time beside the patient. Mrs. C. recounted that in a vague way she had sensed that she was sufficiently important so that someone cared.

When the patient speaks, listen; call him by his right name; give praise whenever possible; be interested in his interest of the moment; look for personal truths that give pleasure—sound teeth, beautiful hair, attractive children; notice qualities of special worth; ask questions that the patient can answer; seek information along lines with which he is familiar; and in matters of no consequence regarding treatment, ask his opinion. Never intimidate. Remember that a patient strengthens his confidence of power and safety in telling jokes, revealing his ambitions, and enumerating his accomplishments; enjoy these with him and direct the conversation so as to extract them.

Giving special attention to grooming is a sure way to help the patient build faith in himself. The individual hair-do, the special manicure, individual bright-colored clothes, no buttons off the shirt, no spots on the necktie, shoes in good condition, hose without runners, lipstick of the right color for the particular outfit, the freshly pressed dress or suit, and special grooming for particular occasions—all these make noticeable improvement in attitudes

The well-groomed person experiences an increase in self-respect; he feels greater personal strength, holds his head a little higher, walks a little straighter; his general outlook on life is better, and in an external way and for a temporary time his emotional load is lighter. Hospital personnel realize the value to patients of a beauty parlor.

In helping the patient build faith in himself pay attention to those factors that make the average person feel fit and buoyant. Eating, proper elimination, exercise, and rest are all essential and basic, but for fullness of soul these are not sufficient.

Most people with only two loaves of bread would sell one to buy something that gives emotional satisfaction. Some activities that provide emotional satisfaction are: shopping for tobacco, candy, articles of clothing, etc.; treating others, participating in recreational activities (mutual sharing of personal experience), winning open recognition of special achievements (ward bulletin board), entering into special group activities in honor of the patient about to be discharged (this also encourages others regarding possible discharge and promotes a good feeling toward the hospital). The celebration of birthdays usually brings much pleasure, especially if the room is darkened, there are a few candles, and everyone sings vigorously, "Happy birthday" (this is an acceptable instance in which to use the patient's first name); as cake is a common dessert, birthday cakes are not difficult to manage.

The importance of the urge for self-regard is evident when one considers how it forces people to self-deception and masquerade in everyday living. The nurse who puts on an unattractive bandage immediately speaks of frayed edges or loose rolling; the person who lacks a capacity for his job talks about the impossibilities in the work or against the character of the boss; the viciously selfish person is the one who shouts the loudest about sorrows and sacrifices; the man who plays an unfair trick on another fellow is the one to hate him ever afterward.

Introduce Beauty.—Esthetic perceptions are important components of inner peace. Order, balance, and harmonious decorations contribute to emotional serenity. Untidiness, disorder, confusion, and barrenness are irksome and discouraging. The eye craves light and color.

Attractive flower arrangements arouse pleasant thoughts and feelings. Blinds hung evenly, windows open symmetrically, and

furniture placed correctly contribute to a feeling of repose. Pictures, preferably copies of masterpieces or good originals, provide background consistent with an environment that improves patient attitudes. You should have sound ideas on structural and decorative design, proportion, balance, emphasis, and cultural and artistic values. Review and expand material relating to this angle studied in the course in "Introduction to Nursing Arts." Develop an appreciation of esthetic values. For practical suggestions examine "Art in Everyday Life" by Harriet and Vetta Goldstein (Macmillan).

Activities Demanding Special Effort.—In a remedial approach to the patient, special effort should be expended on the following

1. Utilize the patient's own behavior.
2. Watch for opportunities.
3. Preclude disagreements.
4. Shun definite refusal.
5. Anticipate unnecessary discomfort.
6. Avoid outright defeat.
7. Make combative behavior needless.
8. Prevent undesirable behavior.

Utilize the Patient's Own Behavior.—The intelligent use of the patient's behavior saves energy and often prevents failure. Usually when a young lady wants money from her father she first finds out something about his mood. If he has had a successful day at the office, she frames her request; if he seems out of sorts, she waits for a more propitious time; if she is not sure how he feels, she begins by speaking on irrelevant subjects—even a statement about the weather gives sufficient indication as to the wisdom of pursuit or retreat. The same kind of artifice is of value in the care of patients with pathologic moods and unwholesome attitudes.

Knowledge of behavior characteristics can be made useful; also, patients who are most difficult to care for often have spontaneous changes in mood and attitude.

The patient in a state of elation is distractible and suggestible.

With both hands, Mrs. B. was pulling on the coat of a physician. The physician asked the patient to look out of the window and tell him what she saw; the patient moved to the window and attempted to open it with one hand, keeping the other hand on the physician's coat; then the physician suggested that it takes two hands to open a window.

Keep in mind that active negativism (doing the opposite of what is asked) is not utilized in nursing care. For example, if a physician wants to look into the mouth of a patient who is actively negativistic, do not tell the patient to shut his mouth tightly. Very likely the physician handles the entire situation, but if he does not, tell the patient that the physician wants to look into the mouth and then proceed to open it, if need be with a mouth gag (be sure physician is present).

Increase nursing care at favorable times. The patient who is depressed is more active in the afternoon or early evening; sometimes nursing care that is impossible in the morning can be accomplished quite easily later in the day. Necessary changes in routine need not throw a ward into chaos; they are not essential for all patients or for the same patient indefinitely. It is purely a matter of thinking of the good to be effected and working toward that end.

Watch for Opportunities.—A great deal of general nursing is done on an established time basis, namely, a certain treatment at 10 A.M., a specific medication at 4 P.M.; much of psychiatric nursing care, however, is left to the nurse to administer as and when she can.

Right timing is one of the fine points in nursing care. Even such a simple matter as giving cheer requires right timing. You do not administer cheer at 10 A.M., p.r.n. or in keeping with your own mood; the patient's mood, the patient's emotional needs are of first importance. If a patient is made truly cheerful, cheer comes at a time when he has a part in it.

A word judiciously placed can work wonders in kneading the social dough in the shape of rapport and wholesome emotional reactions. Right timing is especially important in the care of uncooperative patients and patients with combative tendencies. These people do not remain so continuously; the administration of care can be pressed during better moments. Sometimes it is possible to make use of a flower when the fruit is useless or poisonous. A complete meal may be distasteful to a patient, when a dish of ice cream is welcomed; a brisk walk may be shunned, when a stroll in the garden will be assented to gladly.

Preclude Disagreements.—Disagreements destroy harmony in the sick room and rarely occur on truly essential issues. They become a battle of words backed solely by beliefs in which no

one is ever convinced. In such situations it is impossible to alter a patient's beliefs by words. Even a dispute begun in fun may continue through a desire of conquest until anger and enmity are evident. This robs the patient of a feeling of security. Differences of opinion may have to be evident at times, but often when your thoughts and feelings are not in harmony with the patient's, it is sensible and wise to keep them to yourself.

Shun Definite Refusal.—It is very important to keep a patient from reaching a definite negative stand. After a patient has said "No" the patient and you view the situation from entirely different angles. You continue to think and talk in terms of desired results, but the patient's entire self is manned to protect his "No." When a patient says he will not do something, it becomes a matter of pride, of self-respect to defend the course he has taken.

Anticipate Unnecessary Discomfort.—When you know your patient as a person you learn of matters about which he has unhappy or strong feelings, and of things on which you cannot agree. This fortifies you to avoid such subjects or to discuss them without disgruntling the patient.

You may think politics is a satisfactory subject to discuss with male patients. It has great possibilities. But first you need to know how much the patient is interested in politics and which side he favors.

Patients have strong feelings associated with physical imperfections: flat feet, slant eyes, impaired eyesight and hearing, excessive growth of hair, false teeth, bow legs, conspicuous moles, badly shaped fingers or toes, large pendulous breasts, birthmarks, even pimples. These may not interfere with the efficiency or happiness of the individual except when the body blemish is exposed to alien eyes or when the hidden sensitivity is aroused because someone is not sufficiently thoughtful.

Actual therapy for an unhealthy mental attitude associated with physical defects is difficult and delicate to carry out; but, if needed, it is prescribed by the physician, and you are informed of your special part.

Make it a duty to learn what feature a patient might be sensitive about so that you do not distress him by referring to it unnecessarily. It is a wise use of sympathy not to touch upon a point that can produce discomfort.

Avoid Outright Defeat.—Wise avoidance is not cowardly evasion. You must display an air of confidence if the patient is to have confidence in you; in all matters relating to specific orders, therefore, you must remain dominant, escape direct surrender, and avoid outright defeat. As soon as you realize that you are losing ground (you should appreciate this before the patient does), you may compromise for the moment, withdraw, or get support and advice from the head nurse. If necessary you may get additional help. When you are defeated by the patient in important nursing matters, needful confidence is lost—confidence in yourself, confidence of the patient in you.

Make Combative Behavior Needless.—The care of patients with combative behavior is wholly preventive. Causes for such behavior are feelings of hostility (most common), reaction against confinement, and response to hallucinations or delusions. Assultive behavior arises particularly when a patient is forced to do something against his will. Sometimes this is necessary. The nurse's special responsibility is to see that combative behavior does not occur if unnecessary.

When a certain point in the unhappy feelings of the patient is reached his behavior explodes, and a struggle to prevent injury and property damage ensues. As soon as a struggle begins, the possibility for successful management of thoughts and feeling states ends. For the moment, subduing the patient becomes the sole objective and from this action he senses antagonisms and coercion. His active behavior increases. The immediate need changes from attention to moods and attitudes to establishing physical dominance.

If a specific treatment is to be carried out for a patient with combative tendencies, have sufficient help at hand so that it will not be possible for an unfortunate situation to get under way. For meeting this kind of behavior it is helpful to have a team of two or four nurses or attendants who are accustomed to working together. Be sure to tell the patient briefly what is being done and why.

Combative behavior is a defense mechanism and indicates the presence of an opposing force. Force is always aggressive; it causes one to push, hit, trample on the feelings of the patient. Emotional disturbances in the atmosphere are contagious. Likewise, when the patient senses that he lives where peace, kindness,

and fairness exist and that he is among those who understand and protect his interests, he feels no need to defend himself.

Prevent Undesirable Behavior.—A great deal of psychiatric nursing consists in prevention—of fatigue, unnecessary tension, needless irritation, anger, overexcitement, violent attacks, combative behavior, escape, accidents, suicide.

Anyone who has seriously observed the working of emotions knows that before overexcitement is manifest—a deluge of tears, an expression of anger, or an act of violence—there is a period of incubation, a series of evolutions, differing with the temperament of the individual, the cause and degree of pleasure, pain, irritation, etc. You have an especially difficult task with the person who is mentally ill because the behavior is less dependable, less predictable. When you become sufficiently familiar with the patient, however, it is possible to see consistencies in the behavior pattern.

The successful psychiatric nurse recognizes signs in behavior that point to unfavorable subsequent behavior and does something about the situation in this prodromal period. She either changes the patient's thoughts and feelings or informs the head nurse of her observations. There is a positive correlation between the reduction of undesirable patient behavior and adequate qualified nursing personnel.

Additional Activities.

1. Appeal to the senses.
2. Watch ventilation and temperature.
3. Use salutary discipline.

Appeal to the Senses.—Patients have acute sensibilities; make use of this in nursing care. In general, remove a hospital atmosphere; make the place comfortable and cozy, especially on quiet and convalescent wards. Avoid drab, dispiriting surroundings. When this has been accomplished, patient attitudes are improved, workers take on more zest, and even relatives are definitely softened in their feelings toward the hospital. In appealing to the senses pay attention to the following:

1. Eye.
 - a. Color. Stimulating colors are yellow, gold, red, pink, violet, and turquoise blue; sedative colors are blue, green, brown, mauve, and white. Use cut flowers of appropriate color, especially small bouquets of one or

two flowers, on small dining tables. Consider room decoration from a standpoint of color—curtains, coverings for chairs, cushions, and hassocks; pictures; satisfactory arrangement of color in the room. Let the lamps, particularly the shades, supply color and beauty.

- b.** Pictures. If possible have good pictures, copies of masterpieces (pleasurable recognition, feeling of comfort in line, balance, etc.); the subject is important, for example, pastoral scenes are peaceful (transfer of feeling tones).
- c.** Food. Consider general appearance as well as color.
- d.** Furniture. Place correctly as to type, size, and arrangement.

2. Ear.

- a.** Increase pleasant sounds. People with agreeable voices are an asset on the ward. Encourage birds to come and build nests on the hospital grounds; have a canary or two on the sun porch. The sound of running water is pleasing—a stream, a brook nearby, an indoor fountain on the sun porch. Music has a special place.
- b.** Reduce unpleasant sounds. Prevent unnecessary noise in daily routines. Treatment rooms should be removed from the ward. "Noisy" patients should be segregated in soundproof rooms and wards.

3. Taste. The means of reaching the sense of taste is through food. A qualified dietitian and a good cook are necessary hospital personnel.

4. Smell.

- a.** Pleasant odors. Flowers, shrubbery, and trees are sources of pleasant odors. Some that are especially valuable in this respect are: pine, honeysuckle, lilac, lavender, heliotrope, carnation, phlox, sweet alyssum, mignonette, sweet William, narcissus, hyacinth, and flowering currant. Plant sweet-smelling flowers near the ward; distribute single flowers to be held and smelled. Good soap and toilet water are always pleasing, especially to women; a few drops of good perfume make one feel better even if the bottle is only sniffed once or twice every day. Make use of aroma from spices and hot sauces for food. Have picnics in the woods.

- b. Disagreeable odors. Avoid or remove disagreeable odors. The most common offensive odors are from perspiration, body secretions, and bad breath; also hospital odors of ether, disinfectants, and food cooking, such as cabbage. If a patient dislikes a particular odor, e.g., lilac, keep this in mind and do not thrust it upon him (anticipate emotional needs).
5. Touch. Emotional satisfaction from touch is not stressed enough. Just think what clean underwear, clean outer clothes, and clean bedding do to feeling states. There is a joy in touching good fabrics. Comfortable chairs and cushions have a well-known place. The back rub is valuable. Also, in talking with patients place a hand on the arm or the shoulder. A friendly feeling will communicate itself to the patient (transfer of feeling tones).

Watch Ventilation and Temperature.—The proper ventilation and temperature of a ward or room have a noticeable influence on reducing restlessness in patients. Humidity is important.

The best temperature is 68° F. by day and 65° F. by night. The temperature, particularly at night, depends much upon the age of the patient and how much he is out of bed.

Ventilate the ward several times a day at regular periods. If need be, have patients put on coats and hats. Always open windows during ward exercises and when patients are out of the ward in dining rooms. Air bed well. Strip beds before breakfast, fold clothes neatly at the foot of the bed; do not make up beds until after breakfast. Turn mattresses daily and put out of doors to air at regular times.

Use Salutary Discipline.—You are the disciplinary figure in the patient's environment. Unless specifically ordered by a physician, the disciplining of a patient is a matter of cooperation.

Salutary discipline depends largely on the spirit and attitude of the worker. A child does not continue to tell lies when he lives in an atmosphere of truth; a loud voice is softened in the presence of a quiet, well-modulated one.

Ward activities discipline a patient. Certain activities, such as physicians' ward rounds and rest period after lunch, take place at regular times and require a definite type of behavior from the patient. It is interesting to watch the way patients voluntarily fall in line with specific requirements.

Measuring Success.—In modifying moods and changing attitudes, the initial step is to study a remedial approach to the patient. A long-term course of care is required; success is not measured fairly from a single situation. The patient is not a piece of putty to be molded and shaped to suit the nursing personnel. He thinks, has definite feeling states, makes decisions, has will power. Often his decisions and will run counter to treatment and care. Frequently in single situations the patient has more of whatever it takes to win—knowledge, wit, ingenuity, intelligence, foresight, and personal strength. Sometimes failure relates wholly to a particular time.

Fortunately, success does not rest with one situation or even with one patient. Think more about the following questions: Are you successful some of the time? In your presence is the patient's emotional distress decreased or increased? Does the patient show you respect and esteem? Does the interpersonal relationship usually improve when it is not satisfactory in the beginning?

Success in psychiatric nursing consists in getting results through achievement. When success does occur, it is usually seen chiefly by comparing similar situations of an earlier date.

Nursing care does not necessarily mean pleasing the patient or doing what he wants done; it means providing what he needs but, at the same time, helping him to learn to meet his own needs. Many of the delicate peculiarities of the problem cannot be put into words.

REFERENCES

BOOKS¹

- AVERRILL, LAWRENCE A. and FLORENCE KEMPF: "Psychology Applied to Nursing," 3rd ed. rev., W. B. Saunders Company, Philadelphia, 1946.
- BERNHARDT, KARL S.: "Practical Psychology," McGraw-Hill Book Company, Inc., New York, 1945.
- COOPER, ALFRED M.: "How to Supervise People," McGraw-Hill Book Company, Inc., New York, 1941. (This is written from a commercial or industrial point of view; however, principles on interpersonal relationships are helpful.)
- CUNNINGHAM, BESS V.: "Psychology for Nurses," D. Appleton-Century Company, Inc., New York, 1946.
- HARRIMAN, P. L., L. L. GREENWOOD and E. E. SKINNER: "Psychology in Nursing Practice," The Macmillan Company, New York, 1942.

¹ See list of textbooks for nurses on page 163.

- HULL, C. L.: "Principles of Behavior," D. Appleton-Century Company, Inc., New York, 1943.
- LAIRD, DONALD A.: "The Technique of Handling People," McGraw-Hill Book Company, Inc., New York, 1943.
- Moss, FRED A.: "Psychology for Nurses," Houghton Mifflin Company, Boston, 1941.
- MUSE, MAUDE B.: "A Textbook of Psychology for Nurses," 5th ed., W. B. Saunders Company, Philadelphia, 1945.
- O'HARA, FRANK J.: "Psychology and the Nurse," 2nd ed. rev., W. B. Saunders Company, Philadelphia, 1943.
- POFFENBERGER, A. T.: "Principles of Applied Psychology," D. Appleton-Century Company, Inc., New York, 1942.
- RAUTH, REV. J. EDWARD and SISTER M. MAURICE SHEEHY: "Principles of Psychology for the Basic Course in Nursing," The Bruce Publishing Company, Milwaukee, 1945.
- RUCKMICK, CHRISTIAN: "Psychology of Feeling and Emotion," McGraw-Hill Book Company, Inc., New York, 1938.
- VARNUM, WALTER C.: "Psychology in Everyday Life," 2nd ed., McGraw-Hill Book Company, Inc., New York, 1942.
- WARNER, W. L.: "Color and Human Nature," American Council on Education, Washington, D. C., 1941.
- WEBB, E. T. and J. B. MORGAN: "Strategy in Handling People," Garden City Publishing Company, Inc., New York, 1930.
- WHITE, WENDELL: "The Psychology of Dealing with People: Serving the Need of a Feeling of Personal Worth," 2nd ed., The Macmillan Company, New York, 1941.

ARTICLES

- BONNER, CLARENCE. "Industrial Nursing: The Psychiatric Approach," *The American Journal of Nursing*, May 1944, pp. 470-472.
- JONES, DORIS R., et al. "Approaches to the Psychiatric Patient," *The American Journal of Nursing*, January 1938, pp. 28-36.
- SALLEE, BETTY. "Why Fear the Psychiatric Patient?" *The American Journal of Nursing*, February 1944, pp. 142-144.

CHAPTER IV

NURSING CARE: PRIMARY PERSONALITY DISORDERS

PSYCHIATRIC DISORDERS

Classification.—From a nursing point of view psychiatric disorders are studied in relation to (1) primary personality disorders and (2) secondary personality changes.

The primary personality disorders are those in which behavior yields the primary symptoms of illness. These are of psychogenic origin and do not show structural change. They include *psychoses* in which there is no known organic pathology—manic-depressive psychoses, dementia praecox (schizophrenic reaction), paranoia and paranoid conditions, psychoses with psychopathic personality, and psychoses with mental deficiency. (A psychosis is a mental condition in which there is profound disturbance in the whole personality; the individual's behavior is out of intellectual control.) The symptoms also include *psychoneuroses*—hysteria, psychastenia or compulsive states, neurasthenia, hypochondriasis, reactive depression, and anxiety state. (A psychoneurosis is a mental condition in which there is only partial disorganization of the personality; the relationship to reality is usually well preserved; the person has insight and is not totally incapacitated.) In the primary personality disorders the behavior presents consistent reaction patterns, and the fundamental principles of care are seen best in dealing with patients who have these illnesses.

Secondary personality changes are disorders in which the mental disturbance is associated with another illness; there is always a primary physical diagnosis. In these conditions there are known lesions in the central nervous system or known toxic agents that disturb the functioning of the central nervous system. Psychological constituents also enter in, and some of the behavior mechanisms of the primary personality disorders can be seen. From a psychiatric point of view nursing care is chiefly the application of the principles used in the care of patients suffering with primary personality disorders.

Types of Behavior. *Overactive.*—Overactivity (hyperactivity) is observed in mania, catatonic excitement, and psychoses with psychopathic personality. General points on nursing care are as follows:

1. Attend to personal hygiene: Give plenty of fluids and extra nourishment (energy is consumed in activity); keep up body weight; have the person stay out of doors as much as possible; watch elimination; bathe at least once a day.
2. Provide for the use of excess energy; this means space as well as activity.
3. Protect others as well as the patient.
4. Prevent combative, destructive behavior; accidents; injuries; suicide; exhaustion.
5. Have sufficient help to meet any immediate need with equanimity.
6. Reduce stimuli: people, noise, activities, and especially stimuli that particularly irritate.
7. See that the immediate environment provides a quieting influence.

Underactive.—Underactivity (hypoactivity) is seen in depression, catatonic stupor, and some psychoneuroses. General points on nursing care are as follows:

1. Attend to personal hygiene: Bathe frequently, using friction to stimulate circulation; watch for urine retention and fecal impaction; keep up body weight, by feeding if necessary and giving extra nourishment; provide regular exercise; push out-of-door activities; from time to time change the position of the patient in a stupor.
2. Watch for symptoms of physical illness (patient will not complain).
3. Encourage, reassure, and praise whenever possible; do not give the patient reason to feel isolated.
4. Initiate and stimulate activity but do not push beyond fairly comfortable limits and watch for fatigue; encourage occupational therapy, particularly in depression; develop group activity.
5. Introduce known material—familiar objects, old ideas (old to the patient), former interests.

6. Study the problem of indecision: While the person is very ill, make all decisions, even minor ones (to force responsibility gives real distress and strengthens unwholesome reactions); consult with the physician and use judgment in daily situations.
7. Prevent suicide (this is a paramount problem with depressive behavior, particularly depression with agitation).

Seclusive.—Seclusive tendencies are seen mostly in schizophrenic reactions. General points on nursing care are as follows:

1. Stress contact with reality, particularly contact with *you*. Do not let the seclusive patient, even the one in a catatonic stupor, remain alone; talk to the patient and, in order to provide warmth on your side of interpersonal relationships, consider him as a satisfying companion even though this must be done through imagination; make activity necessary—if there are two activities to be carried out do not try to combine them to save time and energy; search for potential interests and, as the patient improves, get him into congenial groups.
2. Keep the patient neat and tidy.
3. Be alert to assaultive or suicidal behavior; if these occur, there is little warning.

For details on nursing care, see discussion of affective indifference, page 140.

SPECIFIC SYMPTOMS

From a nursing point of view the outstanding symptoms of primary personality disorders are elation, depression, affective indifference, suspicion, and unwholesome attitudes. Nursing care is developed around these particular symptoms.

Elation. Elation is seen best in the manic-depressive psychosis of the manic phase.

General Picture.—Elation refers to mood. Elation may range from unusual alertness and energetic living to a state of delirious mania. For an idea of elation that interferes with the efficiency of the individual and the peace of his neighbors consider the activities of the average person as proceeding at a speed of 35 miles an hour and then think of these same activities as speeded up to an imaginary 40 to 90 plus miles an hour.

More Detailed Picture.—In this disorder (manic-depressive psychosis, manic phase) the affective change is the central feature. The person is elated, and the elation easily goes over into irritation and anger. There are motor restlessness, general overactivity, and a tendency to argue. The person is alert, keen, lively, witty, entertaining, and laughs a great deal. The joviality has a superficial quality; now and then you will see tears and trembling. Critical sense and judgment are overwhelmed by the buoyant enthusiasm and boundless self-confidence. There is rapid association, ideas come faster than the patient can give them expression, and the observer gets only fragments of ideas (flight of ideas) although it is possible to see connections. The patient may be too busy to eat and sleep but never complains about insomnia.

In a state of general excitement the face is flushed, the mouth and lips are dry, and there may be froth from incessant talking; the voice becomes hoarse from shouting and singing; the skin feels dry and hot; temperature may be slightly raised and pulse rate increased.

Outstanding Symptoms.—The outstanding symptoms are the elated mood and increased activity, including overtalkativeness with flight of ideas and excessive psychomotor activity.

Degrees in Elation.—There are degrees of elation. The mildest state of excitement is called "hypomania." This usually continues a fairly steady course, and except for the mild elation and the slight but constant overactivity the person appears quite normal, but his judgment is very poor. At first this person is fun to have around for he is so full of life, so witty, so smart, so enthusiastic, but after a while he becomes the real pest of the ward. He is into everything. He is impatient and dominates every situation of which he is a party. He begins dozens of activities but lacks staying qualities, and all are left unfinished. He always feels abused, demands a chance to prove his "sanity," tells tall tales about the hospital personnel and abuses on the ward, and plays havoc with the relative-hospital relationship.

The extreme form of excitement is called "delirious mania." This condition shows confusion, disorientation, and incoherence; the person shouts, trembles, and picks at clothing. Excitement is continuous.

Detailed Care.—Detailed care of the elated patient is considered under the following: (1) specific orders, (2) the nurse's general

attitude and behavior, (3) outstanding points, (4) additional items, (5) periods of excitement, (6) delirious mania, (7) convalescence, and (8) hospitalization.

In nursing care, *specific orders* hold first place. These relate to hygiene, diet, rest, hydrotherapy (continuous baths and, if the physical condition warrants, cold wet-sheet packs), shock therapy, deep narcosis therapy, recreational therapy, occupational therapy.

The *nurse's general attitude and behavior* should include the following:

1. Consider the patient as a person who thinks and as a partner in the interpersonal relationship. The overactivity, the glibness, the lack of staying qualities, the thoughts that fly hither and thither make it difficult, but this is one of the instances in which you must change your own natural reaction.
2. Be kind, firm, and consistently fair.
3. Disregard delusions.
4. Avoid long conversations. When the person is very ill, he cannot sustain attention; during convalescence long conversations are exhausting.
5. Strengthen the patient's confidence in you. Never deceive; every time any activity is expected of the patient or done for him, inform him briefly as to what and why.

The outstanding points in nursing care are the prevention of unnecessary irritation, an attitude of consistent fairness toward the patient, and sensitivity to increasing excitement.

The prevention of *unnecessary irritation* has to do with the outstanding characteristic of the patient's behavior, namely: Elation turns quickly into irritation and irritation slips easily into anger. This characteristic is obvious and gives rise to the common idea that the person should not be "crossed"—advice relatives always give the attending nurse. The conclusion contains some common sense but is not a sound principle in the care of this type of patient.

If you do not cross the patient when necessary, you will have no positive force in administering care. Except in a state of delirious mania the patient's faculties are working well; therefore, in any

single interpersonal relationship the patient is able to appreciate who holds the position of master.

To be *consistently fair* is an important general principle in the care of those who are mentally ill. This principle is particularly important in dealing with elation. In fact it makes it possible to "cross" the patient when necessary.

The surest way to *control excitement* (if that is possible) and to prevent accidents is to recognize that excitement is on the increase. The following are signs of increasing excitement: The voice becomes louder and more tense; speech increases as to amount and speed; and activity increases (observe the eyes—they sparkle and fairly dance; the hands, and locomotion).

Some additional items to be considered in nursing care are the patient's variations in mood and excessive energy.

Recognize and make use of daily *variations in mood*. While the mood of this type of patient does not fluctuate markedly in one day, there are moments when a slight variation makes nursing care easier for both the patient and you.

The patient's *excessive energy* has to be directed and spent; provision for this needs to be in keeping with the amount of energy produced, and the activity should not be stimulating.

All directed activity is in accordance with specific orders or suggestions by physicians. These plans usually relate to exercises, recreation, and occupation. On the ward the direction of energy is one of your principal tasks; this is especially difficult during mild elation.

There are possibilities in having the patient fold table napkins by the hundreds, dust or wash tables in a cafeteria or dining room, or mow the lawn. In the beginning, activities should require coarse movements, e.g., tearing rags for rugs and rolling them into balls, folding linen, making beds, and carrying out small household duties. Writing material is useful for mild states of excitement.

Games such as ping-pong, medicine ball, badminton, and croquet are helpful. Men find satisfaction in a punching ball. At first games should not be used where there is a competitive element, as this is too stimulating. In all games, until the patient's behavior is under control a nurse should be the partner so that she can watch for signs of increasing excitement, while the patient has the benefit of healthy companionship. Exercise is important both for

reducing excessive energy and for hygienic purposes. Marching in the open air is excellent.

Contact with nature—fresh air, sunshine, birds, fish, trees, grass, land, sky, flowers, water—is a wholesome regulating factor. Have the patient remain out of doors as much as possible.

Another possible aid in the care of the patient in a state of elation is *utilization of the patient's own behavior*. He is suggestible and distractible. When the behavior looks threatening mention almost anything—dinner, lilacs, window—and the thoughts are changed. Always mention something of value or true.

Notice definite trends in *speech* production; make a record from time to time of actual production, as this is important to the physician.

In regard to *sleep*, keep the physician informed; have exact information. Be sure your reports are accurate as to amount of sleep, quality of sleep, and patient activity. The physician bases his judgment regarding sedatives on your report. Do everything possible to promote sleep and relaxation. (See discussion of sleep, page 208.) Paraldehyde is the sedative usually ordered.

The *nutrition* of the patient is important. Preserve the physical condition. Keep the physician informed; have exact information. Watch weight. Keep the patient well nourished without struggle, if possible; utilize variations in mood and watch opportunities. Give large portions at mealtime and provide extra nourishment between meals. If the patient is extremely active, let him take food in his hand—sandwiches or fruit.

In attending to the patient's physical state, give special attention to *oral hygiene*; lubricate the lips.

Another factor is *warmth*. Make certain that the patient is sufficiently warm.

As to *eating utensils*, when necessary reduce these to one spoon and a few light plastic dishes.

In *holding a patient* use care and exert pressure only when necessary. The skin is less likely to be bruised if you put gown or cloth between the patient's flesh and your hand. Better cooperation is obtained if the patient is held with natural positions in mind, e.g., slightly flex the elbow. For better control hold patient by the wrist rather than the hand, and, if walking, walk forward but have the patient walk backward.

Prevent *injuries* such as cuts and bruises. Know when these occur, report them, and prevent infection. Have the patient wear soft shoes (he is apt to kick when angry); keep fingernails short to prevent scratches with possible infection.

The patient's *appearance* must be considered a factor. Give special attention to grooming. Talk with the patient about it; never grow indifferent to his appearance.

Finally, watch especially for *suicidal tendencies* (see discussion of suicide, page 220); *constipation*, *fecal impaction*, *distended bladder* (establish habit time and take to the toilet each time—difficulties are due to poor habits; provide privacy); *dehydration* (give plenty of fluids); and *symptoms of physical illness*.

Sometimes the *periods of excitement* come on suddenly, but usually a keen observer will recognize beginning symptoms. During high excitement the patient is irritable, suspicious, and combative. The following points in nursing care are important:

1. Reduce environmental stimuli.
2. Prevent combative behavior.
3. Watch for signs of exhaustion.

Every minute detail is noticed by the patient, and each stimulus produces a wealth of ideas, which are immediately transformed into acts. Environmental stimuli—people, stimulating color, offensive odors, noises, striking furnishings—should be reduced. Some of the time the patient should be left alone but never neglected. It may be possible to segregate without seclusion. During periods of excitement the patient soon brings in a personal note—you have false teeth, new shoes, etc.; this is unlike the behavior in excitement of schizophrenic reaction.

In a state of excitement, *combative behavior* is easily provoked. Never threaten or imply punishment. Do not criticize, command, or force debatable points. The power of inhibition (the restraining of a function or impulse) is diminished, and thoughts are quickly changed into acts. Sudden requests, sharp answers, peremptory commands, discussion, arguments, and controversial conversations lead to actively aggressive behavior.

Signs of *beginning exhaustion* are perspiration, fever, and increased pulse rate. Profuse perspiration, high fever, and a rapid thready pulse indicate a serious condition. For additional informa-

tion on excitement, see the section on aggressive behavior, page 174.

When the patient is in a state of *delirious mania*, nursing care is limited and consists almost wholly in protection, hygienic measures, and the stabilizing influence of your presence.

It is necessary to provide protection for the patient, from the consequences of his irresponsible behavior, and for other patients, from uninhibited actively aggressive behavior. If too irritated the highly excited patient may become homicidal.

As the patient neglects himself you must carry full responsibility concerning the following *hygienic measures*: nourishment, fluid intake, sleep, and elimination.

There is a quieting influence (transfer of feeling tones) in your presence if you exhibit poise and the absence of hurry; if you have a soft, clear, low voice, and a calm touch; and if you use clear, short sentences in dealing with the patient.

In delirious mania fear is evident at times but is not marked or constant as in delirium tremens or deliriums associated with exogenous poisons such as drugs.

During *convalescence* keep alert for signs of suicide, overstimulation, fatigue (impatience, flushing of the face, inability to fix attention), and depression.

In community life when you are asked concerning treatment or care of a person showing symptoms of a morbidly elated mood, refer the person to a psychiatrist or a hospital. *Hospitalization* is important to protect the ill person from the consequences of his faulty judgment based on the elated mood.

Depression. Depression is seen best in the manic-depressive psychosis, depressed phase. It is also observed in the agitated depression of middle life or later (classified with the manic-depressive group only if there is a history of previous attacks of depression or elation), and in the reactive depression of the psycho-neurotic group.

General Picture.—Depression refers to mood. Depression may range from a blue Monday to a melancholy stupor. For an idea of depression that interferes with the efficiency and happiness of the individual, consider the activities of the average person as being carried on at a speed of 35 miles an hour and then think of these same activities as slowed down to an imaginary 20 to zero miles an hour.

More Detailed Picture.—In this disorder (manic-depressive psychosis, depressed phase) the affective change is the central feature. The person is sad, downhearted, dejected, listless, apprehensive, indecisive; he tires easily; he lacks confidence and underestimates his own ability and achievement—a melancholy error. He answers questions relevantly, but speech and actions are slowed (retardation). He has no appetite. There is an apparent slowness in thinking, although some patients say that they have plenty of thoughts but that they cannot concentrate, organize, or direct thinking.

The skin looks dull, feels cold, and is usually moist and clammy; the hair is dry; fingernails are brittle; body temperature may be subnormal and the pulse rate decreased; muscles are tense; forehead is furrowed. The patient sits alone, and the general posture is downward. He is absorbed in his misery, pays little attention to what goes on around him, is difficult to distract, and feels isolated. When agitation is present he picks and rubs at his fingers, face, and body and may pull out quantities of hair. To the depressed person the past is misery, the present is unbearable, the future is hopeless.

Outstanding Symptoms.—The outstanding symptoms are a depressed mood and decreased activity (psychomotor retardation).

Degrees in Depression. There are degrees of depression. The mildest state is called "simple depression"; this corresponds to hypomania of the manic phase. In simple depression the psychomotor retardation is the marked characteristic.

The extreme form of depression is called "depressive stupor." When activities are slowed to a minimum, the person sits or lies indefinitely without moving so much as to blink an eye, swallow saliva, or discharge urine.

Detailed Care. Detailed care of the depressed patient is considered under the following: (1) specific orders, (2) the nurse's general attitude and behavior, (3) suicide, (4) outstanding points, (5) additional items, (6) melancholy stupor, (7) convalescence, and (8) hospitalization.

As stated previously, *specific orders* hold first place in nursing care. These relate to hygiene, diet, rest, hydrotherapy, exercise, occupational therapy, shock therapy, and drugs (sometimes stimulating agents such as benzedrine or amphetamine sulfate are given).

The nurse's general attitude and behavior should include the following:

1. Subtly establish an atmosphere of hope and cheer—sunny ward, bright colors, sweet-smelling flowers, attractive furnishings, and an atmosphere of kindness, friendliness, understanding, and personal interest. This requires a delicate balance in nursing care. The patient's behavior has a subduing effect on the observer. To show this makes the patient sag further emotionally. On the other hand, if you are noticeably optimistic and buoyant, this makes the patient worse. During deep depression do not attempt to thrust pleasure on the patient; to draw attention to enjoyment in flowers or to suggest a more comfortable chair or position sends the patient further into his intense agony of spirit.
2. Give plenty of individual attention; talk to the patient when he does not respond; as his condition improves, encourage him to talk; ask the same questions over and over, as this does not irritate. No one enjoys a depressed person, and it is easy to neglect him.
3. Reestablish self-confidence: Encourage, reassure, notice accomplishments; praise whenever possible.
4. Strengthen the patient's confidence in you: Never deceive; every time any activity is expected of the patient or done for him, inform him briefly as to what and why.
5. Provide security (see suggestions for reducing fear, page 88).

Every depressed person is a potential suicide, and the unceasing nursing problem is to prevent this from occurring. In the prevention of suicide, the following points are important:

1. Never leave the patient alone.
2. Watch the patient especially in the early morning; when the depression begins to lift, particularly during convalescence; when the patient is in a mild state of depression; and when agitation is present (reduction of psychomotor inhibition).
3. Look for articles secreted for the purpose of self-injury and destruction.
4. Be alert to the swallowing of articles with suicidal intent—needles, pins, and screws.

5. Keep guard over all sharp or harmful articles—knives, scissors, and cleaning fluids.
6. Get the patient interested in something outside of himself—a piece of wood, a game, or another person.

For additional information, see discussion of suicide, page 220.

The outstanding points in nursing care are the reduction of life to a simple level, the establishment of a regular hygienic program of daily living, and the provision of diversion and occupation as directed.

It is painful for the patient to have to think, to concentrate, or to initiate activity. In order to *reduce life to a simple level*, help him regarding these points: Do not force the patient to concentrate or make decisions—do not ask questions that require an organization of thoughts. Try to appreciate that the patient tires easily—do not push activity except as instructed, and watch for signs of fatigue. Do not hurry the patient, even in little things—give sufficient time for a specific activity, appreciating that the amount of time consumed will be greater than for a well person. Keep all communications with the patient as simple as possible—use short sentences and make complete decisions for the patient. Initiate activity—do not just tell the patient to do something; start him on the activity and then do not leave him to his own devices but stay by and assist him as he shows that he is sliding back into preoccupation with sadness.

A definite *hygienic program of daily living* to cover all activities should be established. A schedule, however, is not enough. Very likely *you* are the one to carry out the schedule. At least in the beginning, or depending upon the patient's condition, you may have to wash his face and hands, brush his teeth, comb his hair, walk with him, spoon-feed him, help him to get ready for bed.

To *provide occupation* is very important. If at all possible, do not let the patient sit around preoccupied with his sadness.

In the beginning tasks should be light, simple, for short periods only, and diverting in character. Introduce ideas already known; this requires less mental effort for the patient than paying attention to new ones. Menial tasks often meet an emotional need. Attention should be given to individuals or small groups. Before the patient is ready, competition will prove too tiring and discouraging. A competitive element is introduced gradually; at

the right period in convalescence it can prove a beneficial stimulation. Prevent a succession of failures. Provide worth-while goals, but while the patient is very ill do not talk about the uplifting, soul-satisfying values.

There are several additional items in nursing care that deserve attention. For example, it is helpful to be able to recognize and make use of daily *variations in mood*. Use the improvement that appears in the afternoon and evening to push nursing care. You should appreciate that, besides slight variations in mood, there are variations in the patient's ability to focus attention and to sustain attention on an activity.

Keep physician informed concerning the patient's *sleep*; have exact information. As the patient is apt to be awake in the early morning hours, sedatives used are generally slow acting, such as veronal or phenobarbital.

Keep physician, also, informed of the *nutrition* of the patient; have exact information. Watch the weight. Evidence of the lifting of depression appears in an increase in weight before an obvious change in the mood. Know what the patient eats, how much, and the caloric value; give small amounts at a time. Regarding the problem of not eating, the following points are important: When the depressed patient does not eat, there is concomitant digestive failure. To let the patient go longer than 2 days without food is a serious matter. Giving food (tube feeding) following a period of starvation requires careful consideration as to amount and kind.

Attention to *oral hygiene* means special attention to mouth and lips.

Regarding *warmth* of the patient, be certain that he is sufficiently warm.

Prevent *infection*; protect abrasions or ulceration of the skin.

The patient's *appearance* is important; keep him as well groomed as possible. While he is very ill do not talk much about his appearance.

Contact with *nature* is wholesome; keep the patient out of doors as much as possible.

Finally, watch especially for signs of *suicide* and *escape* (probable suicide). Be alert, also, for *constipation*, *fecal impaction*, *distended bladder* (associated with the general apathy) and *dehydration* (give plenty of fluids for the patient will not make the effort to

obtain fluids). *Nutrition* (preserve physical condition) is important. Watch for signs of *fatigue* and for *symptoms of physical illness*, as well as for *beginning overactivity* (depression often precedes active mania).

When the patient is in a state of *melancholy stupor* nursing care is limited and consists almost wholly in protection, hygienic measures, and the stabilizing influence of your presence.

With this type of patient protection against suicide is necessary. Because of inertness the patient is not so apt to commit suicide; the suicidal hazard, however, is always present.

You carry full responsibility concerning nourishment, fluid intake, sleep, and elimination for the patient. Learn to recognize when the patient is asleep and be able to differentiate between sleep and a stuporous condition. Unless given special attention, the mucous membrane of the eye may become dry, the mouth will get putrid, the bladder will be distended, and the rectum may be impacted with feces.

When you are well-poised, speak in a low controlled voice, use a calm touch, and move about in a steady, unhurried way, your presence has a stabilizing influence.

Special points to keep in mind during the *convalescence* of patients who have been depressed are the importance of group activity (group activities are pushed; pay attention to congeniality of patients) and the need for alertness regarding suicidal tendencies and approaching fatigue.

When asked concerning treatment and care of a person who shows symptoms of a morbidly depressed mood, refer the person to a psychiatrist or a hospital. *Hospitalization* is important to protect the ill person from probable suicide.

Regarding the care of a depressed patient in a home, because of the constant danger of suicide never accept the responsibility for a longer period of time than you are able to remain awake and alert.

Depression with Agitation. Sadness with agitation is usually a depression of middle life or later. The patient is in a state of constant motion: He picks his fingers, head, skin; wrings his hands, sways his body, and moves about in a circumscribed area. He says the same thing over and over again, e.g., "Don't kill me, don't kill me."

This patient has mutilative tendencies: He digs deeply into his

skin, pulls out great quantities of his hair, and he may gouge out an eye or attempt to remove parts of the body that project. Self-depreciation is marked. Delusions of persecution are not uncommon (a projection of insecurity). When sadness and agitation are the outstanding characteristics, retardation is not so noticeable as when there is sadness without agitation. This type of patient is highly resistive but not assaultive.

Special points to keep in mind regarding nursing care are the following:

1. Provide security; the patient's fear is intense.
2. Be alert to possible mutilative tendencies; keep fingernails short; hair may have to be cut close to the head (this requires a special order).
3. Prevent infection from body sores that occur from picking and digging at the flesh.
4. With depressions in middle life, you should realize that very likely the patient is unhappy in the idea of growing old.
5. Do not push the patient either to think or to act; sometimes complete bed rest is ordered.
6. If barbital or bromides are ordered, watch cumulative effect. Chloral hydrate is sometimes given to reduce agitation, and ovarian hormones, such as estrin in oil or stilbestrol, are sometimes ordered.
7. Give the patient opportunity for motion: Have him move from time to time—sit in different places, take a walk (preferably in the fresh air), or dust, sweep, or polish silver (the finished product is not the important point).
8. Do not pick up the patient's mournful repetition as a subject for conversation or discussion.
9. Watch especially for signs of suicide and for intercurrent infection (resistance is low).

Affective Indifference.—The principal disorder is dementia praecox (schizophrenic reaction). Regardless of dynamics, the affective indifference in the schizophrenic reaction is the outstanding symptom (problem) from a nursing point of view.

General Picture.—The behavior in a schizophrenic reaction is much harder to understand than either the elation or the depression. It has a strange, foreign quality; conduct often seems absurd.

There is something wrong with this person's thinking; there is no emotional warmth or attitude of fellowship and harmony; language may be irrelevant and incoherent. Because of these disturbances personal communication is shut off. The patient is in a state of great isolation no matter how many people are around.

More Detailed Picture.—This patient is out of contact with reality. Behavior relates to inner self. When the patient looks at you, you are not sure he sees; when you speak, you are not sure he hears; or if you think he hears, you are not sure he understands; and again, if you think he hears and understands, you will find that he reacts to a small part of what you said and not to the statement as a whole.

The patient is a picture of perplexity and confusion; he shows a helplessness and a hopelessness in arriving at any reasoned judgment. Words may have unique meanings. Sometimes inanimate objects take on life. The patient's own ideas and the things that are real are all mixed up. Language is not a means of communication with others. The negativism seen is not stubbornness but an exaggerated inhibition and comes from unclear thinking.

Moods and attitudes are not appropriate to external events as you view them, e.g., the patient may laugh when told his mother has died; thoughts and feeling states seem detached; words and thoughts do not appear to belong to each other.

Mrs. X. calls a certain physician her son, but when the real son appears she places him correctly and even talks to this same physician about the real son. Yet in her formulations the physician continues to be spoken of as the son.

Mr. Y. considers himself an emperor and asks for allegiance from everyone, yet he goes into the kitchen and washes dishes and apparently sees no incongruity.

Mr. J. just called a pillow "blue." He calls many things "blue"—sometimes it is a pillow, sometimes a chair, or again, a pair of shoes. The color blue is associated in his mind with the woman to whom he was engaged and who married another man.

In his illness, Mr. D. appeared as dead. Upon improvement, he said that he had had the experience of being dead and lying in a coffin suspended in air half way between earth and heaven.

When nursing persons with this type of illness particularly you have to remind yourself frequently that there are no "crazy" people; the absurdity in the behavior resides in your own limited knowledge.

In this illness there are often noticeable physical changes. A cyanosis of the extremities, swollen feet and hands, puffy ankles, and gastric disturbances appear; these are temporary and come and go. There may be a loss of weight to the point where relatives are convinced that the hospital is starving the patient.

The history often reveals that the person as a child was most obedient, never gave any trouble at home or at school, and got along well with studies, but was decidedly shy and timid, did not mix well with others, and seemed emotionally "cold."

Samples of Production. Notice new words, use of words, use of parts of speech, sentence structure, spelling, capitalization, and punctuation in the following:

Sayings:

"Just clean up to my age or whatever you like."

"Yes copyright of day and night
Are meager to consider
Inventions of happiness
For boys are often bitter."

Parts of two letters:

"Years ago I used to have a Meal of the animal Meets. In the year 1935 I decided that I could not support the American Business Principles upon the Destruction of the Live Stock animals.

"Years ago I founded that I could have a satisfactory Meal upon the Serials of the National Grains.

"My Father taught to me the Methods of agericultureal."

"If I am not protected from errors of injustice I am faced with the necessity of defending the chief principles of our institutions to avoid any insidious unconstitutionality as well as other transgressions that may affect the people of the U.S.A., wherein lurks a difficult problem. Laws are treated in the usual elastic manner, and no attempt is made to tighten them up and develop them, for in America much exactitude in appli-

cation and operation of law is lacking. If injustices are not recognized, I will be obliged to stay here, where I have spent seven years and seven months on account of the unjust sentence given me to furnish time in which to carry out vile and immoral actions which have placed me in a critical and scandalous position. The true reverend monsignor is the man who knows how to adapt his practices to his intentions, and not to enforce his will by perilous manoeuvres which are also an insult to institutions and to humanity. With your refined methods of seeking out money and revolutionizing your functions, don't you think that if one could live alone with a little means, one could live in a manner even more worthy according to criteria of equilibrated justice which have the same vocation as yours, but differing in ideas, who hold to a sense of duty, and who know how to evaluate and give good counsel and aid, especially to young people. But someone in America is very antagonistic to this system. Learning one's true origins is not administered substantially in a manner acceptable to humanity, in this promised land, for the benefit of a few, let us leave this and let us take the State Hospitals. What are the authority and the obligations of the population of state hospitals? The irregularities and transgressions that occur in state hospitals is contrary to all institutions and to all men in the order, for we men are out of the order, which actually represents another scandal. Let us return to the argument. With the utmost indifference problems are postulated for solution which are interrelated in an intricate and difficult manner; and the solution is arrived at through hatred and considerations of profit. The requests of the people, which you sustain— are they not a provocation to the people and to morality itself? And what the institutions will not admit—one can take account of force, not of reason and its rules. People may circulate in all parts of the world—and why not in America—why then have we had no contact with justice? Charity in America has no importance. When one is down and out he gets a kick to keep him down, and not a hand to raise him. One cannot say that the U. S. is an orderly, much less civil nation. I have decided voluntarily to cancel my account and not to keep my promise. No one has a regret to deprive one of the liberty accorded him by law and its orderly processes. America has defected its principles; the

American federation is blind to its rights and ignores its obligations, and I am due my rights. The American federation cannot be manipulated by a people. It would lose its scope. Everyone must have the same regret and the same treatment, people from one place as well as from another, and especially those who distinguish themselves by some special spirit. When a man presents himself to a minister to confess himself and completely unveil himself, he asks your advice."

Types.—Besides a general picture, the behavior of patients with affective indifference shows special trends in which a particular line of activity stands out. The well-known types, as presented by Kraepelin, are the following:

1. Simple type. In the simple type there is a reduction in interests, impairment in efficiency, general appearance of untidiness; the affect has some warmth; the person seems absent-minded but not noticeably isolated.
2. Catatonic type. In the catatonic type there is grotesque posturing, stickiness in activity—patient stays in one place, keeps standing, uses one word over and over again; stupor; excitement—differs from manic excitement in that the activity is not clearly associated with external events.
3. Hebephrenic type. In the hebephrenic type there is unexplained smiling; grimacing; manner is abrupt; words are strange; the individual seems to be talking with himself or with some heavenly spirit but definitely not with the person at hand.
4. Paranoid type. In the paranoid type there are delusions relating to sex, personal worth, and persecution.

Major Nursing Problem.—The major nursing problem is to change your own natural attitude of resistance.

The patient's affective indifference presents the real obstacle. A disturbance in fundamental thought processes is evident. This is puzzling but interesting. The affective indifference provides a sense of futility, however, and checks management in thought and feeling. Deep down inside of him the patient wants your company, but the evidence is all against it. He just does not know how to deal with people. He tries to be alone and especially to keep away from anyone who attempts to get close to him. To

consider those who are not friendly as hateful and against you is a natural human attitude. You will want to stay away from this type of patient. However, your objective is to change this natural attitude of resistance to the extent that you will *want* to be with this patient and can persevere in seeking contact with the patient.

Active nursing care calls for great and constant effort initiated within yourself. Often mental and emotional contact with the patient seems impossible. No matter how efficient or how kind you are, you may not get a single response. Without a gratifying response it is difficult to keep objectives alive and to be willing to use the amount of mental energy needed. In caring for this type of patient you must have, first of all, an inner drive (self-impetus). You must be indifferent to immediate success and delight in mental exertion. Gaining personal satisfaction in nursing care depends upon the state of illness and the type of illness. It is much easier to deal with a patient who has been hospitalized only a few months, and it is less difficult to sense an affective warmth in an acute catatonic type than in a hebephrenic type.

That nursing efforts contribute in motivating a desire for health has not been established, but reports from patients upon improvement make the situation a stimulating challenge.

Principles in Nursing Care.—Use active, aggressive policies. With this neutral "frozen" mood, the patient presents a picture of total indifference. His contact with the world (reality) is not satisfying; he shuns association with others and lives as an isolated individual. The general trend in nursing care is to direct the patient's thoughts and feelings toward reality. He must be reeducated. Do not force or drive the patient; lead him with a friendly but constant pressure.

Psychiatric aspects of care are pushed following shock therapy. At this time the patient is in closer contact with reality and reacts to environmental stimuli. His social behavior is improved, but his way of thinking and living must also be changed. This period is used for reorientation to life and problems. You play an important role (outlined by the physician) in helping the patient to grow up emotionally and experience a satisfactory relationship with others.

Detailed Care.—Special points in the care of this type of patient are considered under the following: (1) specific orders, (2) personal

hygiene, (3) indifference and resistance, (4) contact with reality, (5) self-respect, and (6) social consciousness.

Remember that *specific orders* hold first place in nursing care. These relate to diet, drugs (sometimes sodium amyta and barbiturates are used to check excitement; if this patient receives drugs, watch for signs of toxic stupor), shock therapy, hydrotherapy (continuous baths and cold wet-sheet packs are used for excitement, stimulating and cleansing treatments for poor circulation and acne), recreational therapy, and occupational therapy. It is important to keep the physician informed as to sleep and nutrition.

Watch for signs of physical illness, particularly in the catatonic type (swelling and cyanosis of lower extremities and frequent loss of weight indicate physical changes and lowered resistance), sudden death in catatonic type (physical changes may be overlooked because of patient's general condition). Watch, also, for abrasions and skin injuries (prevent infection) and pressure sores, particularly in patients in a catatonic stupor (change position from time to time; use pillows, air cushions, rubber rings, etc., to prevent pressure). You should be alert for signs of contact with the patient's thoughts or feelings, evidence of warmth of affect, outbursts of anger (unpredictable; study behavior previous to outbursts), and suicide (unpredictable, particularly in catatonic and paranoid schizophrenic reactions).

Regarding *personal hygiene*, you will have to accept the entire responsibility. Some points to keep in mind are the amount and variety of food, eating habits, sleep and rest, care of teeth and hair, bathing (use friction—rough washcloth, vigorous rubbing—for poor circulation and acne), elimination (if the patient is careless with excreta, take to the toilet every 2 to 3 hours and watch for fecal impaction; in nursing persons with catatonic stupor give special attention to bladder, bowels, and skin), fresh air, exercise (if active exercise is not possible, passive exercise and massage are usually ordered), posture (change position now and then to prevent injury), warmth (be sure the patient is warm enough). In caring for those who have been ill a long time watch for a tendency to swallow inedible articles.

You may have to begin a particular activity, such as eating or cleaning the teeth, for the patient, that is, guide the necessary movements. When the patient is very ill, each activity will have to be initiated each time.

Habit training is important. Very likely this type of person never had regularity in health habits. He will want to stay in bed when he should be up, get up when he should stay in bed, eat when he is hungry, sleep when he is sleepy. These irregularities have to be corrected. Ward routines contribute to this particular need; also, a definite program or schedule of all routine activities—rising, eating, bathing, toileting, going to bed, etc.—is necessary.

It is important to appreciate, however, that with this type of patient too close an adherence to routine can be damaging in its effect. The purpose of habit and routine is to reduce the use of mental energy on relatively unimportant things. If too much routine allows time that the patient can use in preoccupation, introduce variation to stimulate interest.

For additional points, see discussion of behavior, "Arouse Interest," page 94, and rehabilitation, habit training, page 233.

Tearing down the wall of *indifference and resistance* is difficult but important. In order to do this it will be necessary to change your own natural resistance toward the patient, to provide security, and to keep interested in the patient.

Changing your own natural resistance toward the patient is the ever-present problem. Never give up because you are tired or think the task is hopeless. When your own resistance to the patient's behavior is conquered, the patient's resistance to you will be reduced.

This type of patient needs security, particularly through your own behavior—your integrity, your fairness, your respect of him as a person, and your consistent reactions in patient-nurse relationships.

Sometimes it is afflictive to try to keep interested in this type of person. He is not interested in the environment, in current affairs, in you or anything you have to offer. To the average person the patient would be uninteresting, in fact, irritating. Your attitude must be different.

Ordinarily one would not pursue a one-sided conversation, but you must find pleasure in doing this kind of thing. At some distant time, the patient may respond. Appeal to the patient's sensibilities. Use suggestion. Be concrete. Stimulate activity. The very thing the patient demands—"Let me alone"—is the one thing you must not accept as a general policy. There are times, however, when it is wise to leave the patient alone.

Irritation or anger may be a sign that something has penetrated the wall of indifference and may be viewed with interest and understanding. A study of causal factors should help to differentiate this from activity related wholly to fantasy life. Even though improvement will be due to a total program of treatment and care, you will learn that your efforts had a small but definite part.

Push the patient's thoughts and feelings toward *contact with reality*, at the highest level of his capacity. Some points for consideration are the following:

1. Use simple, concrete language, *e.g.*, instead of saying "meat," say "ham" (or whatever the meat is).
2. Consider sentence construction. Reduce the length of the sentence; pay attention to particular words for emphasis (keep in mind that the patient is inattentive). If there is a basket of flowers in the ward, instead of talking about them, their beauty and fragrance, and suggesting that the patient go over and smell them, lead him to the flowers and say with spirit and interest, "Roses, smell."
3. Break ideas into fragments. Do not ask the patient to get dressed; speak about the socks, and when these are on, proceed to the shirt, etc.
4. Draw attention to things and happenings in the environment; watch for an indication that a stimulus has penetrated.
5. Do not let the patient remain alone for long.
6. Try to get the patient to do things with his hands, *e.g.*, gardening.
7. Put the patient in touch with nature—fresh air, sunshine, trees, sky, land, birds, fish, water.
8. Promote wholesome activities that are stimulating and satisfying to a healthy human being; appeal to the senses; introduce color, flowers, art, music, literature—the amount and kind depend on the patient's capacity. Consult with the physician.
9. Search for potential interests. Find out about the patient's ambitions, hobbies (if he had any), and what he used to like. Know the names of his friends and associates. Watch the daily newspaper for items of interest to him, and if possible scan the daily newspaper from his own home town.

Besides pushing the patient's thoughts and feelings toward reality, help him to find satisfaction in reality. It is not enough to live, one must have something to live for. Know him as a person; be alert to potential interests and leads as to what activities and topics of conversation should be pushed and which held back.

In dealing with this type of patient do everything possible to develop his *self-respect*.

1. Be a friendly, dependable, wholesome companion; do not forsake the patient in his isolation.
2. Treat the patient as a person among persons.
3. Consider that he knows what is going on around him. The patient in a catatonic stupor is particularly deceiving on this point.
4. Show respect by using the appropriate "Mr. (Mrs, Miss)," "thank you," "excuse me," "please."
5. Introduce order. Help the patient keep his towels and toilet articles in place; encourage him to keep his own room or quarters clean and attractive.
6. Respect the patient's belongings. Certain articles and rights on the ward are his; see that these are respected. Do not allow other patients to lie on his bed, use his comb, or smoke his cigarettes unless he offers them. When the physician talks with him, keep others away.
7. Increase the patient's confidence in his own positive capacities; constantly encourage and assure.
8. Keep the patient as well groomed as possible. Send him regularly to the barber shop (beauty parlor); prevent odor of perspiration; give clean clothes at regular times and at other times if necessary (if the patient has an accident and spills soup on his shirt, change the shirt); keep fingernails clean and manicured; see that the shirt is buttoned at the neck, that the necktie is in place, and that shoelaces are tied.

Just to tell the patient that his shoelaces should be tied does not relieve you of your responsibility. Because of his preoccupation or inattention he may not have heard what you said, or if he did it may not have had meaning.

Often you have to do these things for the patient. You may have to tie the shoelaces again and again and again, but each time draw the matter into the field of immediate associations—say how

much nicer he looks when they are tied, that he might fall if they are not tied, joke about it, and so on. Three hundred times would discourage a stout heart, but you are not discouraged that easily.

You do not become discouraged, because you have the concrete aim of having the patient want to do these things for himself, you have enthusiasm, and you have hope that perhaps the next time will produce the desired effect. There is an analogy in the stonemason's attack that finally breaks the stone in two; the break is not the result of the last blow only, but of the others that went before as well.

As the patient's condition improves, his *social consciousness* is developed.

1. Teach him the place of "mine" and "thine," e.g., just as certain articles and rights on the ward belong to him and are protected for him, so he must recognize and protect the articles and rights of others. Never forget this need and your responsibility in it.
2. Push social (group) activities and team work; reduce passive activities. The physician will give orders and suggestions. Orders regarding recreational and occupational therapy usually give special attention to group adjustment and socialization of the patient's interests.
3. Be a pleasant companion, thereby letting the patient experience satisfaction in interpersonal relationships.

The care of the patient with a schizophrenic reaction is a test of nursing ability, capacity, and interest. If you have only abridged clinical psychiatry in mind, you have a minimum of equipment with which to meet nursing problems. If you do not understand the patient's needs or are easily discouraged, you can "get by" with giving less of yourself than in any other nursing situation. If you have some understanding and push yourself to capacity, you will find a rich nursing experience that expands to meet the needs of all patients.

Suspicion.—Suspicion that stands out as something by itself is seen best in the disorder known as paranoia. Also, it may appear as a noticeable part of a symptom picture as in the paranoid type of schizophrenic reaction, and it may clearly color the symptom picture as in the paranoid type of involutional psychoses.

Symptoms.—True paranoia is a rare illness. The outstanding symptom is well-systematized delusions of persecution (no hallucinations, no noticeable change in mental powers). Early symptoms include unusual sensitivity, inability to compromise, physical complaints, excessive ambition with a feeling of inadequacy, and placing of failure on others. Reality is distorted. The delusions of persecution are logically elaborated but are built on a false interpretation of an actual fact or situation; the false conviction or belief dominates the picture.

During the first few years of the condition the mental faculties remain intact and the intelligence is well preserved; in fact, the total personality does not show much change. In other words, the symptoms are not marked. Often the person has a history of legal difficulties. After a while the chief complaint (delusions of persecution) becomes evident but seems innocuous, and the person may be truly dangerous before he appears ill to the average observer.

Nursing Care.—Nursing care is considered under the following: (1) specific orders, (2) the nurse's general attitude and behavior, and (3) special points.

As in all nursing care, *specific orders* hold first place. For this type of patient they are few. You will have many nursing problems but very little tangible working equipment.

As for the *nurse's general attitude and behavior*, since this type of patient is able to take care of himself in matters of personal hygiene he will resent too much attention. He is clever and usually has had relationships with important people or business. In this connection, it is difficult to know when to follow up his requests and when to disregard them. His rational behavior, his cleverness, his important connections, and his air of self-assurance and superiority—actually he feels inferior—make you feel that he is right even though you know that he is wrong. You soon appreciate that anything you say or do is inadequate. The following suggestions may help:

1. Approach the specific problem as follows: The patient will try to talk about the way he has been wronged, which people are against him, why they "have it in" for him, and what he intends to do about it. Your course of action is to realize that you have nothing constructive to offer the patient. This

is not even the place to be a good listener. Sooner or later you will have to tell the patient that you are happy to talk with him on just about any subject but himself; it will help to say so early in the interpersonal relationship and then carry it out—this will be hard to do. You must be alert to significant evidence of impending unfavorable behavior.

2. In all dealings with the patient, be precisely honest.
3. Give direct answers to all questions. If the question refers to the specific problem (and it probably will), let the patient know right from the beginning that this particular matter is not discussed in any way between you. This is another instance in which it is wise to appear stupid and uninformed; besides, when you consider that you have satisfactory answers only your ignorance lets you think so. Refer the patient to his physician.
4. Be guarded in all conversation and be especially alert to untoward responses; misinterpretations come easily. Even to let the patient get in a wedge, so to speak, in the conversation to talk about his problem is a mistake. One of three things will happen: There will be no satisfactory way to bring the matter to a close, an increasing sense of helplessness will make you defiant before you are aware of it, and if you have the stronger side of the situation, the patient will project his antagonisms onto you, after which you can no longer be of any positive help.
5. Develop satisfactory relationships in healthy activities and interests—books, art, music, and games.

There are several special points in nursing care that deserve attention. The nurse should make use of *significant material*. Be alert for and record a change in delusional content or an expression of ill feeling toward another patient or staff member.

It is important to watch for possibilities of *suicide* or *homicide*, especially the latter.

Any *letters* and *outside contacts* of the patient are significant. Be alert to the mailing of letters and outside contacts made through new nurses and attendants, visitors, etc.

This type of patient has *asocial tendencies*. It is helpful to appreciate that he works best alone. His suspiciousness, extreme sensitivity, jealousy, and inability to stay in the background or

accept defeat make satisfactory group activity difficult; beware of competitive activity.

Let the patient have as much freedom from *routine* as possible. Too much routine increases the patient's tension, yet he cannot be allowed to do just as he pleases. Physicians and the head nurse will give definite instructions.

As to *carrying responsibility*, this patient may be able to assume a good deal. He can be of real help in planning activities for special occasions, such as Fourth of July and Halloween, and in providing ideas for theatricals.

The patient may be subject to *delusions*. When he brings God into his delusions, he is dangerous because he imagines that he has supernatural power.

As always, it is important to watch for symptoms of *physical illness*. The patient is helpful because he will complain.

To summarize, the outstanding points in care of the patient suffering from paranoia are the following:

1. Be honest to the letter and in the finest detail.
2. Avoid any talk on the chief complaint—persecution, unfair treatment by relatives, community, or hospital.
3. Watch for indications of delusions about a particular person (possible homicide), also for suicide.
4. Appreciate that the patient works best alone and requires tasks in keeping with his intellectual capacity, which is often high.

Unwholesome Attitudes.—Unwholesome attitudes are seen best in the psychoneuroses (neuroses).

General Picture.—Unwholesome attitudes are present in all people who are mentally ill; from a nursing point of view, however, these attitudes stand out as the primary and almost only practical problem in dealing with patients of the psychoneurotic group.

The behavior in this type of illness is quite different from that previously discussed. Mood disturbances, if any, are mild. Insight and contact with reality are intact. The individual is sane (legally responsible for his acts) and is rarely found in hospitals for the mentally ill where admission is by commitment.

The striking thing about these patients is the general appearance of health. However, unwholesome attitudes are evident even upon immediate contact. These are manifest in severe constant nervous-

ness, specific fears, preoccupation with physical symptoms, egocentricity, indecision, fatigue, emotional childishness, and fixed ideas that sometimes make the person act in a certain way. The unwholesome attitudes are set and give a definite rigidity to the behavior, which in turn makes for handicaps in social relationships and occupational achievement.

Miss. C. has a paralyzed arm. She had been engaged for many years but did not marry because of a duty to her father who is paralyzed. When she was 30 years of age her fiancé said that either they were to marry or he would consider the engagement broken. She became ill.

Mrs. T. is confined to her bed most of the time with sick headaches. She married at thirty-five. Her husband is emotionally immature; their lives are dominated by his mother.

Mrs. T. is nervous and has numerous physical complaints—headache, vague pains, and abdominal distress. The patient is intelligent and a woman of education and refinement. She married when she was twenty-two and has three children. The husband is good but useless. The patient's financial resources have been sacrificed; the oldest boy who had been giving some financial help was drafted into military service.

This type of patient is trying, even exhausting, to have around. She does not keep you "on the mental stretch" like the patient with manic reaction, but your own feeling of helplessness in getting results in the modification of behavior makes you think that the problem is too hard.

In comparing a patient with a psychoneurosis to one with a psychosis, it is difficult for the initiate to realize that the psychoneurotic person is ill. However, from a mental point of view the neuroses are important, for they are responsible for the bulk of the world's cripples and are the major factor in unhappy homes.

Nature of the Illness.—The term "psychoneuroses" refers to a group of illnesses caused by psychic factors. Overwhelming fear or anxiety are converted into physical or mental symptoms. There is always deep inner conflict. People have inner forces and urges which affect thoughts and feeling states, and when an environmental situation brings two opposing forces forward, a tremendous battle goes on within. When the need or drive on each side is equally strong and neither side wins, a compromise is reached through the symptoms of illness.

Types.—A type relates to a particular clinical picture. From a nursing point of view types are unimportant, but the symptoms provide leads regarding the care of the patient. Types of psycho-neuroses with outstanding symptoms may be grouped as follows:

1. Hysteria. This is characterized by physical suffering. Outstanding symptoms are: conversion (an unresolved emotional conflict is presented as a somatic disturbance, e.g., blindness), amnesia (loss of memory), childishness (craving for sympathy, annoyance over trifles), and fears or anxiety hysteria (characterized by conversion symptoms plus recurring attacks of anxiety).
2. Psychasthenia or compulsive states. Symptoms include obsessions (insistent unwished-for thought, e.g., foul word or phrase), compulsive tics and spasms (e.g., jerking of the head), compulsive rituals (e.g., washing the hands), and phobias (e.g., fear of inclosed places).
3. Neurasthenia. Symptoms of this type of neurosis are fatigue —motor and mental (the fatigue is not in keeping with the exertion as it is caused by emotional tension), reduced power of concentration, distress in the head and back of neck, and fear.
4. Hypochondriasis. Physical complaints and obsessive preoccupation with the body (condition of health, various organs, and physical symptoms) are the outstanding symptoms.
5. Reactive depression. The depression is associated with a specific situation (obvious cause). It is not deep-seated, and there are marked fluctuations in mood. Cerebral retardation is not present, and there is little effect on appetite and sleep. There are no delusions or hallucinations. (Compare with depression in manic-depressive psychosis, depressive phase.)
6. Anxiety state. This type is characterized by marked constant anxiety (fear, tension, restlessness, fatigability, inability to concentrate) with episodes associated with physical symptoms of fear (palpitation, dyspnea, nausea, diarrhea). These people are the worriers in an exaggerated form.

Significance of Symptoms.—In thinking about the symptoms of this type of patient, remember that his egocentricity is caused by

fear (anxiety), his indecision is an expression of inner conflict, his fatigue is caused by emotional tension, and his physical symptoms stand for something other than physical illness.

Additional points to keep in mind are that the symptoms are not imaginary but are beyond the conscious control of the individual. To the patient they serve a useful purpose. The symptoms are incapacitating.

Pain is pain whatever the cause. If you do not understand that emotional conflict can give rise to physical symptoms, even though there are no physical findings, you have not yet learned enough about the mechanisms of behavior. A physical symptom can appear in place of an unworthy wish. Probably the simplest and most common example of an emotion giving rise to a physical symptom is the headache which makes it possible for a person to be excused from an unpleasant social obligation. The patient is honest; he is neither a weakling nor a malingerer.

The behavior of the psychoneurotic patient is nearly normal; he has good use of his intellectual faculties and is evidently intelligent—all of which makes it easy to think that the patient could be different if he so willed. The person is ill; symptoms are beyond his conscious control. The symptom, uncomfortable as it may be, is nature's way of throwing up a defense and sparing the person unbearable emotion. Regardless of the cause, pain, blindness, or paralyses are incapacitating.

A helpful attitude toward the patient with symptoms of these illnesses is an appreciation that you and he do not look upon the problem from the same point of view. You deal with the *product* and can draw a clear-cut, logical conclusion. It all seems quite simple. The patient deals with the *process* and is all tied up emotionally, which makes a logical conclusion impossible without help.

Detailed Care. Detailed care is considered under the following: (1) specific orders, (2) outstanding points, (3) nursing needs relating to particular behavior, (4) physical symptoms, (5) suicide, and (6) symptoms of physical illness.

In all nursing care, *specific orders* hold first place. These relate to diet, hydrotherapy (particularly tonic baths), recreational therapy, and occupational therapy. The general trend in treatment is toward emotional reeducation. Medical orders for this type of patient are few; nursing problems relating to interpersonal relationships are many.

Probably the outstanding nursing responsibilities relate to the nurse's general attitude and behavior and a planned program that fills the day with wholesome activities.

As to the *nurse's general attitude and behavior*, in caring for this type of patient exercise a friendly, objective, therapeutic attitude. The patient needs a friend—not a chum who will do anything that comes along but a person who stands on the side and gives strength and assistance when and where it is needed. Some specific points to keep in mind are the following:

1. Do everything to build the patient's self-confidence: Make him feel that he is not only wanted but welcome; never censure; give him plenty of individual attention; and help him to utilize his assets. Make opportunities for him to appear in satisfying roles, and increase his sense of personal worth, especially in relation to the immediate group.
2. Be tactful, firm, and considerate; do not pamper.
3. Be matter-of-fact regarding symptoms.
4. Provide security.
5. Reassure and encourage—not in small measures or in relation to symptoms. For example, do not tell the patient that he moved his paralyzed leg so much today and that he will move it more tomorrow. Always employ the truth and use the top level of praise—you are fine, clever, speedy, a good sport—as situations permit. Keep away from a discussion of symptoms, unless specifically instructed by the physician. A safe place to reassure and encourage the patient whose leg is paralyzed without an organic cause is in a game of chess well played. Wholesome inner feelings have transferable qualities.
6. Develop skill in conversation. Talk about interesting things—new books, music, and art; items of local, national, and international concern; and outstanding people.
7. Sublimate through constructive interest. Make it your business to learn what will interest the patient outside of himself.
8. If this patient is being psychoanalyzed, be especially guarded in everything you do or say. Keep the physician informed regarding patient-nurse relationships; probably the physician will hold frequent conferences with the attending nurses.

As to the modification of the behavior of this type of person, spend time in study on yourself in order to discover particularly what you have to offer in relation to wholesome companionship. In mind and spirit you need to have a sensitivity to the patient and his welfare, but always see his behavior in terms of cause-and-effect relationships. The latter requires an appreciation of the nature of the illness and an understanding of the significance of the symptoms.

It is important to have a *planned program*—to establish by schedule a daily program of activities, including getting up, dressing, washing the face and hands, cleaning the teeth, getting ready for meals, eating, carrying out duties such as bedmaking, tidying the room or ward, toileting, bathing, special therapies, exercise, recreation, going to bed—and to know that the patient meets the program. The advantages of such a plan are that it suggests a beginning (initiates activity), provides purposeful activity, regularizes life, removes the need to make independent decisions, and gets the patient's interest on something outside of himself. The plan should meet the particular patient's individual needs, but it should be sufficiently elastic to allow necessary changes.

Regarding personal matters, the patient takes care of himself. You do not have to wait on him and do things for him. Your usual responsibility is to direct and supervise his activities; to see that he lives in an atmosphere of health—a balance in work, play, rest, and faith; to keep him busy with activities which foster life—growth, development, and productive capacities; to help him become a socially efficient individual.

Sometimes a system of reward and punishment is advisable. This refers to privileges given or withheld according to the patient's behavior. If the patient does not meet required responsibility or obligations he is not allowed to take part in pleasurable activities, or if he carries out his obligations well, he is given additional privileges and responsibilities. These are directed by the physician.

Definite wholesome obligations plus a rhythmic pattern are important. A schedule acts as a control. There should be a program planned for each patient of this type. The head nurse makes out tentative plans, the physician approves, suggests changes, or makes the plan more adequate for the patient's particular needs.

A few suggestions concerning nursing needs relating to particular behavior follow:

1. As this type of patient overreacts to stimuli, do not employ active, aggressive policies; give thought in making the approach of the moment fit the patient as well as the occasion.
2. Because the patient is so susceptible to external influence, use positive suggestions; avoid saying what not to do.
3. Recreation will have to be directed, as many patients do not know how to relax and enjoy play. In observing behavior pay special attention during recreation.
4. Do not depend upon the patient for information on intimate behavior—sleep, nourishment, elimination (particularly as to bowel movements).
5. Do not inquire into the patient's state of health: "How do you feel? How did you sleep? Is your headache better?" Even "How do you do" as a means of greeting is unfortunate. Do not discuss symptoms. This is another instance in which your real cleverness consists in not knowing much about such matters (and that is no pretense). If the problem becomes acute, refer the patient to his physician or let the physician know of your problem.
6. Some of these patients are too fussy about their personal appearance; when this is so, help to establish a healthy, balanced point of view.
7. Appreciate that most of the unpleasant, wearing characteristics in the behavior of this type of patient, especially his complaining, his trying to get attention, and his demanding treatment, are due to fear, usually a gnawing fear of life.

On a medical and surgical ward a *physical symptom*, such as pain, immediately causes concern in your mind and heart. The procedure consists of learning more about the pain—the exact location, its nature (dull, sharp, continuous), and how long the patient has had the pain. You usually get this information from the patient himself. On the psychiatric ward you are expected also to learn more about the pain, but not by asking the patient. If the physical symptom is functional in nature, any discussion feeds the symptom.

In people suffering with psychoneuroses the physical symptoms are sometimes severe and incapacitating; fundamentally, however,

the symptom stands for something else. It is useless and injudicious to make the symptom itself the focal point of attention. The physician will guide nursing requirements.

There is an interesting point that should be noted here on the difference between psychoneuroses and psychosomatic medicine. In the psychoneuroses the cause of the condition is psychic, and there are no physical findings. In psychosomatic medicine the cause of the condition is based on or influenced by psychic factors, and there are physical findings.

Although you do not discuss these physical symptoms with the patient, be keenly aware of the true symptom situation in order to evaluate it, otherwise the beginning of a serious physical condition will be overlooked.

A possibility of *suicide* must be kept in mind.

Because of physical complaints without physical findings it is easy to overlook *physical symptoms* with a physical basis. Very likely every psychiatric nurse, at one time or another, has overlooked a physical symptom caused by an organic condition. Any radical change in behavior should arouse suspicion. Regarding seizures, see p. 204.

PSYCHOSES WITH PSYCHOPATHIC PERSONALITY

Psychopathic Personality.—Social limitation is the central feature of psychopathic personality. Psychopathic tendencies appear in childhood, and most textbook writers consider the condition as one of defect rather than change.

Symptoms.—Outstanding symptoms of psychopathic personality are poor judgment regarding moral and ethical matters, marked emotional instability, and impulsive behavior. Additional symptoms include unreliability, petty misdemeanors, trouble making, inability to profit by experience (expresses regrets and makes elaborate promises, but asocial and antisocial behavior continues), and the fact that difficulties are present from a comparatively early age.

Words do not describe the symptoms adequately. The person is defective from a social point of view, and his behavior plays havoc in group living, but there is a compensatory faculty that covers up the symptoms. These people lie and know that they lie; however, they can make the other fellow believe that they

are telling the truth. They get almost anything they want—money, goods, other people's wives or husbands—and when they get in a jam they can make others believe in their innocence. Knowledge of the characteristics of this type of person and his personal history, as well as study over a long period, are necessary.

The intelligence of the person with a psychopathic personality is usually average or above average and the appearance is usually satisfactory, but close observation discloses a shallowness in reasoning, lack of depth in emotion, and abnormal egotism. These people are pathological liars, criminals, sexual perverts, and inadequate personalities. Their social maladjustment takes them to reform schools, work farms, and prisons. They are unamenable to treatment—social, medical, and penal. Quite probably the prevalence of the problem in the armed forces will lead to publications of interest and help.

Psychosis.—Psychotic reactions occur, either as episodes or as a condition covering a longer period. These people are frequently in legal difficulties and are sent to hospitals for observation to determine responsibility for conduct. The symptoms are an exaggeration of previous behavior.

Treatment.—Most reports are pessimistic as to outcome of treatment. The general trend in treatment is as follows: For small children, a rigorous course of habit training; for young people, a routine for living, with pressure situation removed if possible and reeducation introduced (psychoanalytic techniques are used by some psychiatrists); for adults, sedatives to control overactivity, and penal institutions.

Nursing Care.

1. In routines that have been set up hold the patient to his responsibility; do not allow relaxation in obligations and responsibilities. Activities need some challenge and variation, as this type of patient craves excitement and cannot tolerate simple monotonous routine. Confinement and frustration occasion outbursts of activity.
2. In interpersonal relationships do not be fooled by the patient's pleasant manners and lively, rational, even brilliant conversation.
3. Place the patient in situations where he can obtain socially acceptable satisfactions.
4. Watch for symptoms of physical illness.

PSYCHOSES WITH MENTAL DEFICIENCY

Mental Deficiency.—Intellectual limitation is the central feature of mental deficiency (feeble-mindedness); the condition is viewed as one of defect rather than change. Mental deficiency is either primary or secondary. The primary condition is present at birth or congenital; the secondary condition is a matter of arrested development and occurs from injury or an infectious disease during the first few years of life. This is a separate and special field of study.

Symptoms.—In mental deficiency the individual is unable to learn by experience and training, he lacks insight and is unable to evaluate.

Degrees in Deficiency.—The quantitative defect can be measured by intelligence tests. The standard classification is as follows: idiot—intellectual quotient 20 or under; imbecile—21 to 50; moron—above 50 but below 70.

Psychosis.—Psychotic reactions occur in these persons, either as episodes or as a condition covering a long period; the behavior pattern is less complex than in people with normal intelligence. Common symptoms are fear, temper tantrums, hallucinations and fabrication, unpredictable behavior, and assaultive behavior if provoked.

Treatment.—The treatment consists largely in custody (protection) and training. The latter is in keeping with the intellectual capacity and relates to muscular coordination and control, personal cleanliness, assisting self in such matters as dressing and undressing, eating, and bathing; social and manual activities.

Nursing Care.

1. In general, protect; supervise constantly; teach; direct; be informed as to the definite training program; watch for symptoms of physical illness; appreciate that enuresis (bed-wetting) is common; place emphasis on occupation, recreation, and habit training.
2. Give praise freely when due.
3. Prevent fatigue, as this affects undesirable behavior; give simple tasks—menial, monotonous work is handled best; do not demand sustained effort.
4. Prevent unnecessary irritations; protect from others—it is

unfortunate when these people must live with others who have a greater intellectual capacity; do not place in competitive situations unless among equals.

SUMMARY

Care of patients with primary personality disorders comprises the subject matter from which all psychiatric aspects of nursing are taken. The purely psychiatric aspect is concerned chiefly with interpersonal relationships, particularly with the modification of behavior. Nursing activity is not confined to the material in this chapter, however, but includes the essentials covered in the entire book.

REFERENCES

TEXTBOOKS FOR NURSES

- BAILEY, HARRIET: "Nursing Mental Diseases," 4th ed., The Macmillan Company, New York, 1939.
- BIDDLE, W. EARL and MILDRED VAN SICKEL: "Introduction to Psychiatry," W. B. Saunders Company, Philadelphia, 1943.
- BUCKLEY, ALBERT C.: "Nursing Mental and Nervous Diseases from the Viewpoint of Biology, Psychology and Neurology," 5th ed. rev., J. B. Lippincott Company, Philadelphia, 1938.
- CHADWICK, MARY: "Nursing Psychological Patients," George Allen & Unwin, Ltd., London, 1931.
- INGRAM, MADELENE E.: "Principles of Psychiatric Nursing," 2nd ed., W. B. Saunders Company, Philadelphia, 1944.
- KARNOSH, LOUIS J. and EDITH GAGE: "Psychiatry for Nurses," 2nd ed., The C. V. Mosby Company, St. Louis, 1944.
- MOERSCH, F. P.: "Neurology and Psychiatry for Nurses," Burgess Publishing Company, Minneapolis, 1935.
- NOYES, ARTHUR P. and EDITH M. HAYDON: "A Textbook of Psychiatry," 4th ed., The Macmillan Company, New York, 1946.
- RICHARDS, ESTHER LORING: "Introduction to Psychobiology and Psychiatry," The C. V. Mosby Company, St. Louis, 1941.
- SANDS, IRVING J.: "Nervous and Mental Diseases for Nurses," 4th ed., W. B. Saunders Company, Philadelphia, 1941.
- STELLE, KATHARINE McLEAN: "Psychiatric Nursing," 2nd ed., F. A. Davis Company, Philadelphia, 1941.

OTHER BOOKS

- BENNETT, A. E. and AVIS PURDY: "Psychiatric Nursing Technic," F. A. Davis Company, Philadelphia, 1940. (This is a manual.)
- BRADLEY, C.: "Schizophrenia in Childhood," The Macmillan Company, New York, 1941.

- BRILL, A. A.: "Freud's Contribution to Psychiatry," W. W. Norton & Company, Inc., New York, 1944.
- CALL, A. P.: "Power Through Repose," Little, Brown & Company, Boston, 1891, 1914.
- CHENEY, CLARENCE O.: "Dementia Praecox (Schizophrenia) Group." "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- CLECKLEY, HERVEY: "The Mask of Insanity," The C. V. Mosby Company, St. Louis, 1941. (Psychopathic personality.)
- COBB, STANLEY: "Borderlines of Psychiatry," Harvard University Press, Cambridge, 1943.
- COON, G. P. and A. F. RAYMOND: "A Review of the Psychoneuroses at Stockbridge," Austin Riggs Foundation, Stockbridge, Mass., 1940.
- CRUTCHER, HESTER B.: "Foster Home Care for Mental Patients," Commonwealth Fund, New York, 1944.
- EBAUGH, F. G.: "The Care of the Psychiatric Patient in General Hospitals," American Hospitals Association, Chicago, 1940.
- GORDON, R. G., Editor: "A Survey of Child Psychiatry," Oxford University Press, London, 1939.
- HENDERSON, D. K. and R. D. GILLESPIE: "A Textbook of Psychiatry," 5th ed., Oxford University Press, New York, 1940.
- HENDERSON, D. K.: "Psychopathic States," W. W. Norton & Company, Inc., New York, 1939.
- HENDERSON, D. K.: "The Affective Reaction Type (Manic-Depressive) Including Involitional Melancholia." "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- HENRY, GEORGE W.: "Essentials of Psychiatry," 3rd ed., William Wood & Company, Baltimore, 1938.
- HINSIE, LELAND E.: "Visual Outlines of Psychiatry," Oxford University Press, New York, 1941.
- HORNEY, KAREN: "Our Inner Conflicts: A Constructive Theory of Neurosis," W. W. Norton & Company, Inc., New York, 1945.
- HUNT, J. McV., Editor: "Personality and the Behavior Disorders," The Ronald Press Company, New York, 1944. (Particularly Vol. II, Part VI, "Some Outstanding Patterns of Behavior," and Part VIII, "Therapy and the Prevention of Behavior Disorders.")
- KAHN, EUGENE: "The Psychopathic Personalities." "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- KANNER, LEO: "Child Psychiatry," Charles C. Thomas, Publisher, Springfield, Ill., 1935.
- KARNOSH, LOUIS J. and EDWARD M. ZUCKER: "A Handbook of Psychiatry," The C. V. Mosby Company, St. Louis, 1945.
- KASAKIN, J. S., Editor: "Language and Thought in Schizophrenia," University of California Press, Berkeley, 1944.
- KRAINES, S. H.: "The Therapy of the Neuroses and Psychoses. A Socio-biologic Analysis and Resynthesis," Lea & Febiger, Philadelphia, 1941.

- LICHENSTEIN, M. and S. M. SMALL: "A Handbook of Psychiatry," W. W. Norton & Company, Inc., New York, 1943.
- LORAND, SANDOR, Editor: "Psychoanalysis Today," International University Press, Publishers, New York, 1944. (26 contributors.)
- MASSERMAN, JULES H.: "Dynamic Psychiatry." W. B. Saunders Company, Philadelphia, 1945.
- MILLER, E., Editor: "The Neuroses in War," The Macmillan Company, New York, 1940.
- NOYES, ARTHUR: "Modern Clinical Psychiatry," 2nd ed., W. B. Saunders Company, Philadelphia, 1939.
- ROGERS, CARL R.: "Counseling and Psychotherapy—Newer Concepts in Practice," Houghton Mifflin Company, Boston, 1942.
- ROSS, T. A.: "Psychoneuroses." "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- SLADEN, FRANK J.: "Psychiatry and the War," Charles C. Thomas, Publisher, Springfield, Ill., 1943.
- SMALL, S. M.: "Symptoms of Personality Disorders," Family Welfare Association, New York, 1944. (Monograph.)
- SOLOMAN, HARRY C. and PAUL YAKOVLEV: "Manual of Military Neuropsychiatry," W. B. Saunders Company, Philadelphia, 1944. (45 contributors.)
- STRECKER, E. A. and F. G. EBAUGH: "Practical Clinical Psychiatry," 5th ed., The Blakiston Company, Philadelphia, 1940.
- STRECKER, E. A.: "Fundamentals of Psychiatry," 3rd ed., J. B. Lippincott Company, Philadelphia, 1945.
- STRECKER, E. A. and K. E. APPEL: "Psychiatry in Modern Warfare," The Macmillan Company, New York, 1945.
- WHITE, W. A.: "Paranoia and Paranoid Conditions." "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- WHITNEY, E. ARTHUR: "Mental Deficiency." "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.

ARTICLES

- "Advanced Course in Psychiatric Nursing," *The American Journal of Nursing*, July 1944, pp. 683-689.
- ACETO, TERESA, et al. "A Psychiatric Nursing Care Study," *The American Journal of Nursing*, October 1945, pp. 842-848.
- BETZ, BARBARA. "A Psychiatric Children's Ward," *The American Journal of Nursing*, October 1945, pp. 817-821.
- BOSSELMAN, BEULAH. "The Evolution of a Schizophrenic Process in a Young Boy," *The Psychiatric Quarterly*, April 1945, pp. 258-266.
- BROWN, MARY JANE. "Psychiatric Nursing in Naval Base Hospitals," *The American Journal of Nursing*, December 1945, pp. 1135-1137.
- CAMERON, D. EWEN. "Some Relationships between Excitement, Depression and Anxiety," *The American Journal of Psychiatry*, November 1945, pp. 385-394.

- CAMERON, NORMAN. "Schizophrenic Thinking in a Problem-solving Situation," *The Journal of Mental Science*, September 1939, pp. 1012-1034.
- CREAK, E. M. and B. J. SHORTING. "Child Psychiatry," *The Journal of Mental Science*, January 1944, pp. 365-381.
- CRICHTON-MILLER, H. and GRACE H. NICOLLE. "Psychotherapy," *The Journal of Mental Science*, January 1944, pp. 307-315.
- CUDMORE, WILLIAM E. "Psychosis with Psychopathic Personality: A Study of Eight Cases," *The Psychiatric Quarterly*, July 1939, pp. 457-465.
- CURRAN, DESMOND and PAUL MALLINSON. "Psychopathic Personality," *The Journal of Mental Science*, January 1944, pp. 266-286.
- DESPERT, J. L. "A Comparative Study of Thinking in Schizophrenic Children and in Children of Preschool Age," *The American Journal of Psychiatry*, July 1940, pp. 189-213.
- EAST, W. NORWOOD. "Delinquency and Crime," *The Journal of Mental Science*, January 1944, pp. 382-398.
- GILLESPIE, W. H. "The Psychoneuroses," *The Journal of Mental Science*, January 1944, pp. 287-306.
- GLUECK, BERNARD. "Contemporary Issues in the Relationships between Psychiatry and Law," *Journal of Criminal Psychopathology*, October 1939, pp. 91-102.
- GREENACRE, PHYLLIS. "Conscience in the Psychopath," *The American Journal of Orthopsychiatry*, July 1945, pp. 495-509.
- HAYMAN, MAX. "The Interrelations of Mental Defect and Mental Disorder," *The Journal of Mental Science*, November 1939, pp. 1183-1193.
- HINSIE, LELAND E. "The Psychiatric Patient and the Law," *The American Journal of Nursing*, May 1939, pp. 513-514.
- JUNG, C. G. "On the Psychogenesis of Schizophrenia," *The Journal of Mental Science*, September 1939, pp. 999-1011.
- KAPLAN, LILLIAN K. "A Coordinated Therapeutic Approach to Schizophrenia, Analysis of Techniques Used in One Case," *The Psychiatric Quarterly*, January 1945, pp. 90-121. (The therapeutic program was one of combined medical, psychiatric, and environmental factors.)
- KUBIE, LAWRENCE. "The Repetitive Core of Neurosis," *The Psychiatric Quarterly*, January 1941, pp. 23-43.
- LEVERING, IRMA. "Nursing Care in Schizophrenia," *The American Journal of Nursing*, October 1940, pp. 1077-1083.
- LEWIS, AUBREY. "Depression," *The Journal of Mental Science*, January 1944, pp. 256-265.
- LINDEMANN, ERICH. "Symptomatology and Management of Acute Grief," *The American Journal of Psychiatry*, September 1944, pp. 141-148.
- LIPCHUTZ, MAJOR LOUIS L. "The Background of Military Psychoneurosis," *Military Surgeon*, November 1945, pp. 384-388.
- MAYER-GROSS, W. "Irritability as a Symptom in Manic Depressives," *The Journal of Mental Science*, January 1937, pp. 61-70.
- MAYER-GROSS, W. and NORMAN P. MOORE. "Schizophrenia," *The Journal of Mental Science*, January 1944, pp. 231-255.
- MENNINGER, W. C. "Psychoneurosis—A Summary for the Nurse," *The American Journal of Nursing*, May 1945, pp. 348-350.

- MENNINGER, W. C. "Depressions," *Diseases of the Nervous System*, February 1941, pp. 244-253.
- MORITZ, LOWI and LOUIS COHEN. "Comprehension-Defects in the Psychoses," *The Journal of Abnormal and Social Psychology*, October 1945, pp. 391-400.
- PENROSE, L. S. "Mental Defect," *The Journal of Mental Science*, January 1944, pp. 399-409.
- PRICE, ANTOINETTE. "Understanding the Neurotic," *The American Journal of Nursing*, August 1937, pp. 878-881.
- SHERMAN, IRENE C. and SAMUEL B. BRODER. "Dr. H. Singer's Concept of the Psychoses," *Archives of Neurology and Psychiatry*, May 1943, pp. 732-738.
- SHULACK, MAJOR NORMAN B. "Exhaustion Syndrome in Excited Psychotic Patients," *The American Journal of Psychiatry*, January 1946, pp. 466-475.
- STOCKINGS, G. T. "A Study of Acute Neurotic Depression as Seen in Military Psychiatry and Its Differential Diagnosis from Depressive Psychoses," *The Journal of Mental Science*, July 1944, pp. 772-776.
- VIGOTSKY, L. "Thought in Schizophrenia," *Archives of Neurology and Psychiatry*, May 1934, pp. 1063-1077.
- WEISS, MADELINE O. "Nursing Care of Psychoneurotic Patients," *The American Journal of Nursing*, January 1946, pp. 41-42.
- WOLF, MARGUERITE. "The Role of the Psychiatric Nurse in Therapeutic Situations," *The American Journal of Nursing*, December 1943, pp. 1115-1117.
- WOODS, W. L. "Schizophrenic Thinking," *The Journal of Nervous and Mental Disease*, March 1938, pp. 290-316.
- ZIEGLER, LLOYD. "Depression as the Chief Symptom," *The Psychiatric Quarterly*, October 1939, pp. 689-696.
- ZILBOORG, GREGORY. "Misconceptions of Legal Insanity," *The American Journal of Orthopsychiatry*, July 1939, pp. 540-543.

CHAPTER V

NURSING CARE: SPECIAL PROBLEMS

The special problems in nursing care discussed in this section are (1) accidents, (2) aggressive behavior, (3) elimination, and (4) escape.

ACCIDENTS

Accidents are reduced to a minimum when there is adequate and properly instructed personnel. Even then accidents occur.

General Data.—The following information regarding accidents is interesting: Most accidents occur on the hospital ward. Types of accidents include bruises, burns, choking, cuts, dislocations, fractures, self-inflicted injuries, and injuries in which an employee is involved. Of these, the most common accident is a fracture. The greatest number of accidents occur among the old-age group, the most common cause being a fall. Among the younger group, the most common cause is an altercation.

Nursing Care.—Nursing care consists of prevention, recognition of the presence of an injury, and appreciation of the fact that the patient cannot be relied upon to report an accident or an injury.

Prevention of Accidents. The Patient.

1. If one patient dislikes another, separate the two for the time being; if possible place on different wards.
2. If a patient is disturbed, have him wear shoes with soft soles and heels.
3. Watch patients as they get out of chairs, see that they are steady on their feet when they begin to walk (particularly important with the aged and with those who are receiving sedatives), and assist them if necessary; pay special attention to patients in the bathroom.
4. Reduce irritability and antagonism by having the patient take part in ward activities (utilize interest, direct energy into constructive channels).

Equipment.

1. Chairs should be of heavy construction.
2. Beds should be all in one piece with casters welded to the bed. As falls are common with old people, have low beds or criblike beds for this type of patient.
3. Do not have unnecessary bedside tables on disturbed wards; if used they should be substantial and all in one piece.
4. Glass should be of the correct thickness to be unbreakable. It should be in small squares or reinforced with wire to prevent complete shattering. When glass is broken be sure that all pieces and sharp edges are removed.
5. If a patient frequently runs into a certain chair or table, change the location. Watch patients on waxed and wet slippery floors (floors just mopped or wet bathroom floor). Loose or turned-up rugs, rugs rolled up for the night, steps, and open stairways are all hazards. Dumb-waiters, laundry chutes, and ventilating shafts must be kept locked.

Sharps.

1. Keep all sharps—scissors, nail files, crochet hooks, etc. —belonging to the ward or to the patients in the nursing station. Keep the number of such articles at a minimum.
2. Keep a record of all sharps belonging to the ward and to patients in a book for the purpose, or better still, have two separate books.
3. Sign articles out to the patient as needed, check return of article, and collect all such articles before going off duty for the day.
4. Supervise use of all sharp articles.
5. Check all silverware before and after use. The danger from dining-room silverware is not so much the sharpness of the article as its possible use as a substitute for a screw driver with which to tamper at locks, window catches, etc.
6. Check all sharps regularly, night and day nurse together, before each nurse goes off duty.
7. Collect eyeglasses each evening before the patient settles for sleep; make a record concerning the glasses. Have eyeglasses clearly labeled—place label on the temple and away from the rim so as not to interfere with vision; the case also should be labeled with the patient's name.

8. If there is no barber shop, have certain days for shaving. Keep razor blades in a central office—nursing office or central supply room is best. Give out blades only as needed—if possible the same number each time, e.g., instead of giving a ward three blades one time, four another, and five another, always give five blades even though two unused blades are returned. This simplifies difficulties in times of anxiety. Keep two records, one at the office giving out the blades, the other at the ward receiving the blades. Used and unused blades should be returned as soon as possible.

Medications.

1. Keep all medicines in the nursing station securely locked in a special medicine cabinet.
2. Keep the number of drugs at a minimum.
3. Have only small amounts on hand.
4. Check medications in use and in the closet at least once a week; return unnecessary drugs to drug room.
5. Give special attention to such articles as medicated alcohol or solutions for dressings; do not let these out of your sight for one moment.

Poisons and Dangerous Articles.

1. Do not have these on the ward.
2. If poisons and dangerous articles are necessary (usually they are not, except for razors in the barber shop, knives in the central kitchen, or cutting instruments in the occupational-therapy shop), keep in a central office and give out only as needed, to be returned as soon as used and especially before the particular nursing personnel concerned go off duty.
3. Keep cleaning utensils locked in a closet when not in use.

Burns.

1. Do not allow patients to have matches.
2. Look for matches following visiting hours.
3. Control smoking—have special times and designate a special place.
4. Watch radiators. Protection may be necessary, particularly for the aged and patients suffering with psychoses with syphilitic meningoencephalitis (general paresis); see discussion of secondary personality changes, page 259.

5. If the patient is in a tub or shower, do not turn on hot water without having your own hand at the inflow.
6. Do not allow patients in the bathroom alone.
7. Give special attention to hot-water bottles when used, for these are dangerous articles. Do not have the temperature of the water over 118° F.

Choking.—Choking is common with the aged and with patients suffering from general paresis. With these patients,

1. Cut food into small pieces.
2. Try to slow the patient in his eating habits.

Actual Accident.—When an accident occurs, it should be reported, whether or not there is an apparent injury. Frequently symptoms arise after several days or weeks, and it is necessary to know that there was no evident injury at the time of the accident to which the patient refers. Sometimes these accidents become legal matters months and even years afterward. When there is an accident of any kind, report immediately to the nurse in charge of the ward. The person who is present at the time of an accident should know exactly what happened, what people (if any) were involved, who witnessed the accident, and what was done. For the following specific types of accidents certain definite procedures should be followed.

1. Fall. Report at once to the nurse in charge of the ward; there should be a record of all known falls.
2. Collapse. Usually the patient falls suddenly to the floor. Examine him, count pulse, report accident; later look for injury during fall.
3. Hanging. See discussion of suicide, page 220.
4. Seizures. See discussion of seizures, page 204.
5. Hemorrhage.
 - a. Symptoms. There may be external or internal bleeding. Internal hemorrhage may show only in restlessness, anxiety, thirst, and rapid pulse.
 - b. Care. Report accident; if there is external bleeding, apply pressure directly to bleeding point (if possible use sterile gauze; if there is not enough time, the hand is permissible)—if arterial cut (blood spurts, bright red in color) exert pressure against artery between cut and heart, if venous cut (steady stream, low pressure, dark red in

color) apply pressure at edge of wound away from heart; or apply digital pressure at proper pressure point—for temple region, in front of ear; for face below eye, along jaw bone; for throat, against wind pipe; for shoulder and upper arm, behind collarbone against first rib; for forearm and hand, half way between elbow and shoulder; for thigh, leg, or foot, at middle of groin against pelvic bone. A tourniquet may be applied to extremities; *release every 15 minutes.* A tourniquet is a dangerous instrument, as it stops the flow of all blood.

6. Shock.

- a. Symptoms of shock are pale face; cold, damp, sticky skin; rapid, weak pulse; quick, shallow, generally regular, sighing respiration; profuse perspiration; intense thirst; color is slow in returning after finger pressure to skin.
- b. Care. Report accident; keep patient quiet and apply external heat—blankets, warm if possible, and hot-water bottles (temperature of water not over 118° F.)

It is advisable to keep a standard first-aid book in the nursing station and to be familiar with the contents. If an accident causes an injury of a hospital employee, have the employee report as per hospital routine, probably first to the nursing office or the head of the particular department concerned.

Record.—For standard accident-report form see example on page 173.

The nurse at the scene of the accident reports in detail exactly what happened and what she did. The supervisor investigates the accident and reports a verification of the first nurse's report with any additional helpful information. The ward physician reports the immediate treatment. The clinical director verifies previous reports, gives additional information of value, and states the action taken.

An employee's error or failure in carrying out a hospital rule is not recorded here; administrative-employee relationship is a separate matter.

Examination of Reports.—From time to time, examine accident reports; make comparisons; see if there is a particular hazard that could be eliminated, e.g., if several patients trip over a certain rug, something must be wrong either with the condition or the location of the rug.

CLARINDA STATE HOSPITAL

ACCIDENT REPORT

Name _____ Number _____ Ward _____ Date _____

Report of nurse:

Nurse

Report of supervisor:

Supervisor

Report of ward physician:

M.D.

Report of clinical director:

M.D.

AGGRESSIVE BEHAVIOR

Meaning.—The aggressive behavior that presents a special nursing problem and that is discussed here is active and destructive. Assaultive, combative, and destructive behavior is a problem in hospitals for the mentally ill, a problem that stands in direct relation to adequacy of personnel.

Emotional tension is discharged chiefly through words and actions. Increased tension and reduced intellectual control mean noise and general activity; also, every aggressive act not held in check means additional aggressive acts. However, when nurses and patients understand each other, and when the patient has a better understanding of his own problems and needs, aggressive behavior is reduced to only an occasional occurrence.

There is also an element of aggressive behavior that has a passive quality. Here the nursing problem of self-discipline is great; however, the ward is not subjected to a destructive force. In this form of aggression the patient talks at length on important subjects, giving his opinions and yet constantly belittling his judgment and apologizing for being so bold as to express an opinion. He talks on and on. He keeps you waiting, guessing, and standing. He makes demands particularly when you need to be doing something else or are about to go off duty. It is very difficult to have clean-cut, quick dealings with this type of person; yet you cannot keep away from him, for he sees that you have obligations to him. Like most patients, he is afraid, lacks self-reliance, feels insecure, inferior, and unimportant. This indirect way of demanding attention and the constant humility are all a mechanism for gaining importance and bolstering up courage.

Prevention of Extreme Excitement. Nursing Responsibility.—The prevention of extreme excitement or of active aggressive behavior is primarily a nursing responsibility.

General Points.—Successful nursing care is measured by achievement and requires special study and experience in the field of psychiatry. In general, you should know the symptoms of aggression. You should be able to recognize beginning excitement and know which patients become disturbed easily and why. When patients become excited, never show an attitude of defense. When patients fight with each other, know which one is the leader. If two patients irritate each other, keep them apart; if possible, on

different wards. At the first sign of trouble notify the nurse in charge of the ward; she in turn will probably notify the ward physician.

Specific Points.—Specifically, you are expected to appreciate which patients require special observation, to estimate the cause of aggressive behavior, and to understand initial steps.

Certain patients require special observation, and there are times when disturbed periods are more frequent. Give special attention to patients who are in a state of excitement (with those easily angered, excitement is apt to increase). Patients with delusions of persecution and ideas of influence should also be watched, as well as those who exhibit a period of excitement following a seizure. Patients who are mentally deficient and live in surroundings above their intellectual capacity are apt to indulge in aggressive behavior. The most frequent times for disturbed periods are in the early morning, on getting up, at breakfast, and at bedtime.

Outstanding reasons for aggressive behavior are feelings of hostility, mental and physical distress, response to hallucinations or delusions, and certain environmental factors.

Feelings of hostility may be against the world in general, against certain people and circumstances outside the hospital, or against the hospital itself as representing the immediate, tangible target. Confinement makes for irritation and active behavior; however, reactions against confinement are related to feelings of hostility. Aggressive behavior is noticeably reduced when patients can be taken out of doors. Enclosures for disturbed patients should be as large and beautiful as possible and should not shut out the outside world, that is, the patient should be able to see beyond the enclosure.

In all dealings with the patient, tell him what is being done and why; avoid argument; be delicate in the use of locked doors. Help attendants understand that the patient's language is not personal—"You God damn son of a bitch," or similar remarks, are fighting words to the average untrained worker.

Mental and physical distress are common causes of aggressive behavior—ugly and painful associations, feelings of fear, hatred, and confusion, as well as headache, cold, pain, and toothache.

Nakedness reinforces destruction. Think of yourself as standing naked among those who are dressed; you would feel rougher and tougher and do something about it. The patient is no differ-

ent. He may be naked and destroy his clothes because the clothes are too warm, too rough, too restricting, or simply disliked. If the patient will not keep his clothes on, see that he is *alone*. Appreciate slight changes in behavior. Tomorrow he may welcome what he cannot tolerate today.

Aggressive behavior as a response to hallucinations and delusions is the least predictable and therefore the most demanding on your mental capacity to anticipate and divert, especially until you have dealt with and studied the particular patient's behavior reactions.

Hallucinations, particularly auditory, are a warning to expect impulsive acts. Delusions, particularly those of persecution, mean easy misinterpretation of the conduct of others and subsequent untoward reactions.

Environmental factors that annoy patients and bring about aggressive behavior are the same kind that annoy anyone—irritating personalities, unpleasant smells, too warm a room, disorder, insecurity in dealing with associates. Aggressive behavior is noticeably reduced when there is satisfactory rapport between patients and nursing personnel.

Initial steps in the prevention of extreme excitement are the following:

1. Recognize impending trouble.
2. Appreciate the level of excitement at the moment.
3. Learn the particular patient's way of reacting.
4. Segregate without seclusion.
5. Establish a positive approach.
6. Consider your own behavior.

The cardinal symptom of trouble ahead is *increased restlessness*. With increased restlessness the eyes fairly dance, the hand movements increase in amount and are quicker in character, speech is faster and louder, the entire body is in a state of motion, single movements are short and jerky, locomotion is noticeable. Usually there is a period of incubation; recognize the signs. Even with excitement as seen in the schizophrenic reaction there are signs of development characteristic of the patient.

The level of excitement provides the cue as to what to do, *i.e.*, try to change the patient's behavior course or get additional help immediately.

You should become familiar with the behavior reactions that are characteristic of the particular patient. This helps in perceiving whether to suggest, to distract, or to change the environment completely. Also, it is the only way to appreciate when it is folly to approach the patient and that additional help is needed if demands must be made on the patient at these times.

Sometimes it is helpful to draw the patient away from exciting influences and if need be to conduct him to a seclusion room and leave him alone (not shutting the door).

Develop a positive approach. Never let matters ride along until there is open trouble. At the very first sign of beginning excitement (and catch that first sign) start thinking and then do something—be sure to think first. Better far to make mistakes, even bad ones, than to remain passive; learn from all mistakes, however, and do not make the same mistake twice. Two possibilities are open: you can either change the behavior course or get additional help. If the excitement is not great, try to divert the patient's attention; change the particular activity of the moment or introduce something of interest or affection to him. If the situation is questionable, get help from someone, preferably the nurse in charge of the ward.

It is possible to avert threatening behavior through your own general attitude and behavior. The following points are paramount: You should be able to *evaluate the effect of your presence, sense quickly the immediate result of your effort, and learn when to stay away from the patient.*

Regarding your presence, you will have an emollient effect providing you have a controlled voice, a calm touch, a friendly objective attitude, a sincere interest, good rapport, and know what to do.

If the patient senses a feeling of insecurity or an attitude of defense in you, the situation is already out of hand. The patient must never get the idea that you are ready to take up direct action against him. If you do not know what to do or say, especially if you have a feeling of fear, do not touch the patient or even speak as he will catch your state of feeling in your touch and in your voice (transfer of feeling tones), and it will act as a whip or a release. Go immediately to the nurse in charge of the ward.

In these situations your strength lies within yourself—your qualities of integrity, fairness, and objective friendliness, your

knowledge on the particular patient, and your previous interpersonal relationships with him.

Regarding the effect of your effort, to plan a course of action is not enough; the effect must be recognized quickly. What may work well one time will not necessarily be useful another. The important point is to think and devise strategy, but as soon as the ideas are put into action, recognize whether an attempted approach is unwise, as pursuance may be dangerous.

One of the most important points in the management of aggressive behavior is to learn when to stay away. These periods are usually of short duration, but an attempt to dominate the patient at such times is folly and leads to altercations. If something must be done for the patient have enough people at hand; when a male patient is in a seclusion room a female nurse should not go into the room alone.

Treatment. Specific.—Specific treatment for aggressive behavior hinges upon interviews with the physician and definite orders from the physician for the nursing personnel.

The constructive use of energy reduces aggressive behavior, but the patient has to be at a certain level of health before it is possible to do much in the way of directing energy into constructive channels.

Shock therapy noticeably reduces aggressive behavior; the goal in such treatment, however, is not wholly to reduce overactive behavior.

When a patient is in a state of excitement, treatment consists chiefly of hygienic measures and protection.

Hygienic Measures.—When a patient is in a state of excitement, the nursing personnel is responsible for personal hygiene—cleanliness, nutrition, elimination, fresh air, and sleep. The nursing care of the excited patient with an acute condition differs somewhat from that of the patient with a chronic condition.

With chronic conditions, a definite routine may be necessary regardless of the patient's behavior of the moment. In such cases be sure there is enough help.

With acute conditions, you do much more adjusting to the patient. The behavior is not quite so set and slight fluctuations in mood and attitude make it possible to push nursing care at certain times. For example, you may realize that you could give the patient a bath at 4 P.M. without struggle and that he might even

enjoy it; give the bath then, unless meeting an established schedule for bathing is a part of treatment.

Protection.—People who are not responsible for their own acts require protection. This is the essence of legal commitments for admission to hospitals for the mentally ill. In the hospital the person whose behavior is actively aggressive must be protected against himself and from injuring others. The need to protect the patient is met by placing him in the particular ward suited to his condition and by means of seclusion and restraint.

Patients in hospitals are grouped on *wards* largely in keeping with their social behavior. The behavior varies greatly. The more aggressive and destructive the behavior, the more the patient is protected.

Antisocial behavior requires further segregation and grouping within the hospital. In this way the naked patient is protected by being alone, the overactive patient is saved unnecessary irritation in having to deal with people whose activity proceeds at a slower pace, the noisy patient is kept from thrusting his unpleasantness on the quiet patient, and the patient carrying out a destructive course in behavior does not disturb the patient who is beginning to become established in a constructive program.

On all wards teach healthy reactions both by pattern and precept, and do not overlook opportunities to improve behavior.

The wards housing patients with overactive, aggressive behavior are usually called "disturbed" wards and are located on the first floor and toward the rear of the hospital, as more accidents occur on these wards. Location on the ground floor reduces accident hazards and makes it easier for the patient to be out of doors. The ward is located in the rear of the hospital in order to keep noise and excitement away from the entrance. No doubt some day hospitals will be built with one or two stories only and will be planned as units adapted to treatment.

The furnishings on a ward are in keeping with the social behavior of the group—disturbed wards are simply furnished.

Furniture has to be reduced in amount and as far as possible should be in one piece (casters welded to beds, no fancy bedside tables with gadgets that come apart), and heavy so that it cannot be thrown around. Floors should be solid and impervious. Dishes have to be either unbreakable or replaceable at low cost. Draperies, if any, are inexpensive. Clothes are always a problem.

Such a ward may have to be plain, but it can have spots of beauty. Even when the greater part of the ward has little comfort or charm, concentrate on a corner or a window. Bring in some flowers, one good lounge chair, or a table with something pretty on it, and you will see that the behavior of some of the patients will change; they will protect that corner, and the whole atmosphere of the ward will begin to show more spirit.

Regarding wards housing patients with aggressive behavior, the nurse's greatest responsibility is not to accept the patient's behavior as stationary and impossible to change. The nurses on a disturbed ward have a difficult task, yet most nurses prefer to be there rather than on a convalescent ward. One reason is that nurses feel at home wherever there is need for great physical activity.

On the wards for patients with acute conditions it is easy to keep up your spirit and feel hopeful, especially when you see that the excitement is temporary; however, the wards for patients with chronic disturbed conditions present quite a different nursing problem.

The teaching possibilities on the latter are limited, and nurses may be fewer in number with the attendant group increased. (There is a certain type of middle-aged attendant who truly enjoys the work on these wards.) The physical effort is great; however, the adherence to definite routines provides a satisfaction for the worker that is absent on wards for patients with acute conditions where much mental exertion must be carried on along with physical activity.

If combative, assaultive, destructive behavior occurs, *seclusion* is an accepted means of protection. All seclusion is carried out by a physician's order. When seclusion is resorted to, the patient's chart should show the physician's order for seclusion, the time of seclusion (beginning and ending), and the reason (behavior) for the seclusion.

The room designated should be used for seclusion purposes only and should be apart from the others. It should be constructed to meet the needs of the patient. For example, temperature, ventilation, and moisture need attention. The window should be near the ceiling and, if the room is air-conditioned, of glass brick; an artificial light with the surface smooth should be placed in the

center of the ceiling; there should be no light fixtures. Rubber tiling makes the best floor; this can be kept clean easily and is protection against accidents. The wall surfaces should be smooth (no low windows or inclosed radiators for patients to pull at or spit and urinate into). There should be no jogs (see diagram).

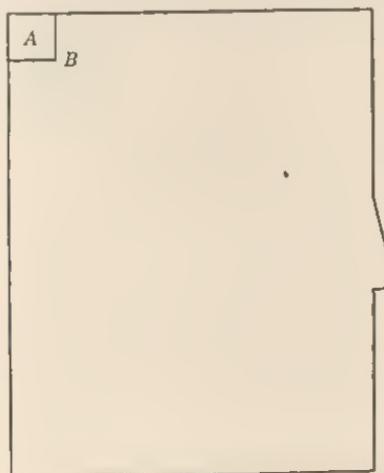


FIG. 6. *A* represents a jog covering pipes; *B* indicates the sharp edge and a suicidal hazard.

The door to the room should open out; there should be no knob on the inside and no way in which the patient can lock himself in. The observation window should be of unbreakable glass, about 5 by 6 in., in the upper part and center of the door and on a level with the eyes of the person of average height. The door should be located so that the entire room can be viewed from the observation window (see diagram on page 182). It is desirable to have the room soundproofed, and if possible it should be air-conditioned, not only for the patient's comfort, but also because it is then easier to make the construction meet the needs.

Furnishings of the room used for seclusion are limited to a mattress, a pillow, and blankets. The mattress should be rubber-covered; an additional cover should be made of heavy material that can be washed. The pillow also should be rubber-covered. The blankets are for warmth; use old blankets and supply the number that are needed. Do not have any articles in the room with which the patient can injure himself or damage property.

Under no circumstances put a bed in the room; if the patient is well enough to have a bed, use another room. Make the mattress up as a bed, and when the patient is not destructive place a hassock in the room.

A patient is never shut in a seclusion room without a physician's order. Seclusion is not a form of punishment. The general idea is to reduce stimuli, and the best time to use this procedure is before the patient becomes extremely excited.

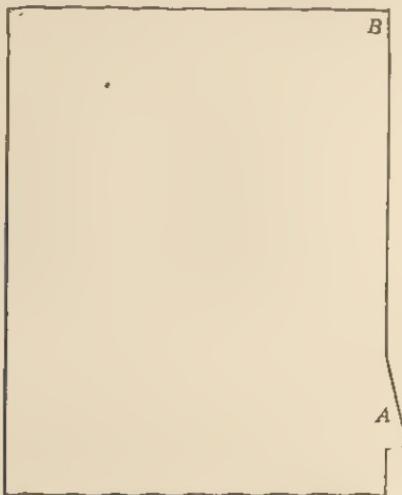


FIG. 7. *B* indicates a spot where a patient cannot be seen from observation window in door *A*.

After a patient's behavior is out of control, it takes several people to place him in seclusion. At such times have sufficient help.

Before putting a patient in the room make sure that he does not have any articles in his possession with which he might injure himself or destroy property. If he is being carried through the doorway, introduce the head first so that hands and feet cannot be used to stop the procedure.

A seclusion room is used only if necessary or expedient. When you and the patient understand the use of the room, it is interesting to see how effectively it works.

The following points in nursing care should be observed after a patient is in a seclusion room:

1. Do not neglect him.
2. Do not leave indefinitely; often a short time suffices.

3. If possible, do not leave the patient in the room longer than 2 hours at one stretch; give opportunity for exercise (toilet every 2 hours).
4. Observe the patient every 10 minutes, noting what he is doing, his level of excitement, and his personal needs (thirst, need to go to the toilet). Do not keep peering into the room as though the patient were an exhibit.
5. Toilet at regular periods, every 2 hours.
6. See that the patient has water to drink; do not leave water in the room.
7. Give food during mealtimes. If possible take the patient out of the room; if not, serve with paper or plastic dishes. If the patient is particularly messy, give only one dish and one article of food at a time.
8. Going into the room depends upon the patient's behavior and particular needs. When the room has a male occupant, a female nurse should not enter alone.
9. When the patient is calm and able to be with others, he is brought back to the group.

The word *restraint* brings to mind the idea of mechanical restraint; however, any method by which a person's activity is curtailed is restraint. Even the locked door is a restrictive force. Drugs, packs, baths, and the holding of a patient are all forms of restraint.

Hospitals without adequate qualified personnel use mechanical restraints in dealing with combative, assaultive, and destructive behavior. Unfortunately, these are the very hospitals in which the personnel is the poorest equipped to deal wisely with such measures.

If mechanical restraint is used, the following points are important:

1. Have a physician's order.
2. Do not place a mechanical restraint directly against the skin; have something soft between the restraint and the skin.
3. Be especially careful of any restraint over the chest, avoid if possible.
4. Consider the type of restraint. Do not restrain a patient in bed if the hands are the only problem. Whenever possible use only the device consisting of a belt and cuff—the

belt goes around the waist with wristlets attached to the belt toward the front. The hand movements are limited, but the patient has considerable freedom.

5. Pay attention to the patient's position; have him as comfortable as possible, and watch the strain on joints.
6. When restraining extremities be careful not to impede circulation.
7. Do not apply restraint to only one area of the body. For example, do not secure both feet to the foot of the bed or restrain an arm and a leg of the same side; the patient can throw himself around and receive serious injury or get into a hazardous position which he himself cannot change.
8. If a patient struggles while in restraint, keep the physician informed, keep a close record of the pulse, and watch for signs of exhaustion.
9. Remove restraints as follows:
 - a. If extremities are restrained, remove every hour (one at a time) and rub the area; use alcohol and powder.
 - b. Take the patient out of restraint completely every 2 hours, unless otherwise ordered by the physician. Toilet, bathe hands and face, give an alcohol rub or a sponge bath, put on a fresh gown (keep two gowns alternating—one on the patient, the other being aired), comb the hair, freshen the bed.
10. Give your own general attitude and behavior special attention. Be particularly kind. This is the very patient whose inner self you have the greatest chance of reaching by the transfer of feeling tones.

Managing an Excited Patient.—The key principle in the management of patients with aggressive behavior is prevention; if a threatening situation has not been averted, however, and an emergency arises it is important to have enough help and to use an established technique.

Enough Help.—In handling an excited patient, the number of workers is important; however, forceful management of the patient depends less on the number of workers than on their qualifications. Do not attempt to handle a questionable situation alone. Never get between two disturbed patients to separate them. Where aggressive behavior is probable, the hospital administration sees

that help is always available. When you sense impending trouble, let the nurse in charge of the ward know immediately.

Technique.

1. At the sign of approaching trouble remove your own glasses, watch, fountain pen, or anything of value. When on duty on a disturbed ward keep these articles at a minimum, out of sight, and as well protected as possible.
2. If the patient is wearing hard shoes, remove these to prevent injury to others.
3. Know exactly what you are about to do.
4. If a female patient is mildly excited, it may be sufficient to walk beside her, placing an arm around her waist and grasping the wrist of the far arm with your hand; with your other hand grasp the wrist of the patient's other arm drawn toward the front of the body. Do not touch a male patient; merely walk beside him with a male attendant present.
5. If two people are handling the situation, there should be one on each side of the patient. Take hold of an arm, flex the arm at the elbow, and place your arm between the patient's arm and trunk and clasp the wrist. Walk with the patient, all walking forward. If the patient is hard to manage, use the same method as above except that the patient's arms are drawn to the back. Have the patient walk backward; the nurses walk forward.
6. If several nurses are taking part, each one should know what is being done and her part toward the total procedure.
7. If the patient is being moved, all workers should know where the patient is being taken so that they can move in the same general direction.
8. To prevent biting, scratching, and hitting, keep behind the patient or at the side; if you take hold of the patient's arm, grasp the wrist.
9. Never take hold of an excited patient by the hand and pull forward; the patient immediately pulls backward and has control of his maximum strength.
10. In applying pressure, as in holding a wrist, have some cloth between the patient's flesh and your hand: this reduces the possibility of bruising. Hold on to the patient, but exert pressure only when necessary. Never exert pressure over the chest.

11. If the patient has a dangerous article, such as a hammer, place first attention on the article. If necessary, throw something—sheet or blanket—over the patient's face; use a mattress as a shield. In extreme situations approach the patient from behind. In hospitals with qualified personnel such needs rarely occur.

Abuse of Patients. *Physical.*—Rumors run rampant concerning physical abuse of patients in hospitals for the mentally ill. No doubt there is some physical abuse from time to time and for the following reasons:

1. Lack of adequate qualified personnel.
2. Poor supervision.
3. A lack of understanding of the patients' behavior.
4. Ignorance of how to deal with threatening situations.
5. Sadistic tendencies in workers.
6. A natural reaction of workers to protect themselves.

Now and then patients do have bruises and black eyes; but they fall out of bed; try to harm themselves; pinch, kick, bite and fight each other. When a patient runs amuck in a hospital, he receives princely handling as compared with a like situation in the community.

Definitely there is no physical abuse tolerated by hospital administrators when they know about it, and the actual amount is probably less than the public would believe.

Psychological.—Very little is said about psychological abuse of patients in hospitals for the mentally ill, yet this is much more common and injurious than physical abuse.

If it does take place, physical abuse is definite and intentional. The patient reacts by swearing, spitting, kicking, biting, and entering into combat as he has a chance. Psychological abuse—indifference, lack of understanding—is unintentional and occurs because of thoughtlessness or a lack of sensitivity to a need. The worker's conduct may be impeccable. However, the abuse is piercing, wilting, and damaging; and, like a kiss from a mother without love in her heart, it offers no point of attack.

The Head Nurse.—The head nurse on a ward housing patients with aggressive behavior holds a very responsible position. She should have knowledge of and experience in psychiatric nursing.

She should be adept at reaching probable conclusions—*this* is happening, *that* will likely follow. Of course she will make mistakes, but unless she habitually reasons this way—and it is more than a hunch, an intuition—patients and workers will be hurt, property will be damaged, and forceful measures that destroy rapport with the patient will be necessary. The head nurse is expected to know when to call the physician. Usually the physician is called when there is any altercation between patient and worker or patient and patient. At the beginning of an upswing in behavior the physician usually wants to talk with the patient. He should be consulted with regard to any measure that requires coercion, *e.g.*, seclusion after the peak of excitement is reached. A physician should be present when specific treatments are being carried out, such as cold wet-sheet pack or sedation for excitement. He should be called at the patient's request, unless the head nurse has been otherwise instructed, and when any unusual happening—accident, attempted suicide, fire—occurs. The head nurse should have an understanding with the physician concerning emergencies, particularly the use of seclusion.

It is the head nurse's responsibility, also, to know which physician to call first:—interne, resident physician, physician who is doing intensive therapy with the patient, or the officer of the day (the officer of the day is called by the ward only for matters of a serious nature—probable suicide, fire). She is also expected to know how to handle emergencies. In nursing problems the ward calls the supervisor first, but in emergencies the possible dangers are too great and come too fast to allow moments to be wasted. Usually the hospital ruling is to call the physician first, then the supervisor. If the hospital has an emergency signal, this is set off before telephoning anyone; hospital personnel know what to do.

ELIMINATION

Nursing Responsibility.—With those who are mentally ill the responsibility regarding elimination rests wholly on the nursing personnel. As most of the patients are ambulatory and many appear well physically, it is difficult to appreciate the seriousness of the problem, especially since the custom in the general hospital is to rely somewhat on information from the patient. On the psychiatric ward you have to know the actual condition, for too often

the patient's opinion is not sound. He may be too busy, too preoccupied, too forgetful, or too ill to give accurate information.

Skin.—Bathing is usually carried out according to a regular schedule; the schedule must be sufficiently elastic, however, to meet patient needs adequately. In a hospital for the mentally ill the individual need takes precedent, so far as possible, over wholesale schedules and routines. Supervision must be objective so that one patient does not get more than his share of attention; to reach a fair balance, however, is not as difficult as it seems at first glance.

If the patients go to a bathhouse on certain days, additional needs must be met on the ward. Patients who soil themselves and smear excreta must be bathed immediately. Patients who are fleshy, have body odors, or who are especially active may require baths in addition to any regular schedule, especially in hot weather. The patient's capacity to manage himself enters into the picture; for example, a patient on the convalescent ward who has just had an active game of handball or tennis should be allowed and encouraged to take a quick shower before dressing for dinner.

The inactive patient too requires special attention. In order to remove waste products use plenty of friction—rough washcloth, vigorous rubbing—if the skin permits.

Regarding perspiration, know the actual condition. If the amount is reduced or increased, report to the physician. Appreciate that the patient whose perspiration is reduced will have a dry, scaly skin and be easily chilled. The patient with excessive perspiration requires special attention; use plenty of soap and water, but do not overlook the possibility of a need for medical attention. Borax is a good deodorant.

Excessive perspiration of the feet gives distress. Provide extra foot baths and clean socks daily (preferably white); keep the skin in good condition and know that the feet are dry. Watch the feet for signs of epidermophytosis. Do not let patients wander about or go to the bathroom barefooted; be careful about any exchange of shoes.

Bladder. Urine.—Be alert to slight changes in the character of urine; notice odor. Be vigilant regarding amount and frequency of urine output. Know the actual daily output; from time to time measure and record a 24-hour period whether the physician orders such a record or not; report and record any actual change or abnormality.

Distention.—In suspected cases of bladder distention inspect abdomen daily. Pay particular attention to patients who are confused or stuporous, also bed patients with incontinence.

Difficulty in Urinating.—Appreciate that old men often have difficulty in urinating. Do not let the patient strain too much; report to physician. Often a warm bath relieves the condition temporarily. If the old man urinates in the bath water, do not scold (do not spoil his comfort from the remedy); see that the tub is given an extra cleaning.

Bowels. Evacuation.—It is important that the nurse know the patient's actual condition and that she learn about his normal state as to frequency and usual time. Report to the physician if bowels do not move for 48 hours.

Constipation.—Constipation is a common physical symptom on psychiatric wards. Patients that require special attention are the overactive (too busy to take time); the inactive, stuporous, and depressed (stimuli are reduced and general apathy prevents activity even of going to the toilet); the emotionally indifferent (do not pay attention to routine and retain urine and feces as a form of resistance); those with unwholesome attitudes (inaccurate regarding intimate behavior); and the aged. With the aged there are diminished sensibilities, and the reduction of solid food in the diet affects the functioning of the bowels. If an aged person has an unexplained fever, look first to the condition of the bowels. Appreciate that old people may have a fecal impaction even when the bowels move some. Note that the above list includes just about every type of patient.

The following measures are used to combat constipation: With regard to the diet, helpful articles of food are: fruit, vegetables, vegetable oils, cereals, and roughage. If special diet is prescribed, see that the patient eats the food prepared or else report to the physician. Exercise is important, especially exercise out of doors. Make and follow a schedule of fluid intake; otherwise the procedure is haphazard and may not meet the need. If the patient had a habit time before he became ill, reestablish this particular time.

It should be emphasized that (1) routine orders for cathartics point to inefficient nursing, (2) fecal impactions occur too frequently on psychiatric wards, and (3) mineral oil is not usually given to undernourished patients.

Incontinence.—Incontinence is an inability to control the bladder or bowels because of an organic defect, such as a paralysis of muscles involved. It is a serious symptom. The condition is found on psychiatric wards, but chiefly in patients with a primary organic illness (see discussion of secondary personality changes, page 259). Patients with this condition should be toileted regularly and fluid intake should be reduced toward evening.

Untidiness. Untidiness is an inability to control excretions because of mental reasons. This is a frequent problem in the care of patients with a primary personality disorder, particularly with those who are on a disturbed ward.

The most common form of untidiness is an output of urine. Sometimes the bowels move anywhere, and patients even handle feces (*excreta decorates*). Many patients spit as a means of release from emotional tension.

Management.—Try to discover the cause for untidiness. Some of the reasons are confusion, delusions, hallucinations, intense emotion; pleasure in infantile behavior; preoccupation.

The patient who expectorates freely should not be allowed to spit in any place he pleases; give him a definite place and keep him there until the behavior improves (consult with physician); see that his mouth is clean and sweet.

Regarding *excreta decorates*, the patient's behavior has meaning, even though this is not always understood by the observer. Put the patient where such activity concerns only himself. Be kind and friendly, never critical. The patient should not be punished, neither should the behavior be considered acceptable. Try to have the patient wash and clean himself, wash the soiled clothes, and remove the wall decorations. Clay modeling has been observed as a satisfactory substitute.

Situations arising from confusion and intense emotion can be improved through nursing care.

Diet.—Consult with physician. See that the patient has plenty of fluids. Report to the physician concerning urine output, as to amount and kind, and the actual condition of the bowels.

Habit Training.—Toilet the patient at definite times, every 2 or 3 hours and $\frac{1}{2}$ hour after meals; the existing condition of bladder and bowels should indicate when and how often to take the patient to the toilet.

Regarding the bowels, know that they are functioning well

Take the patient to the toilet at the same time each day; an excellent time is about one-half hour after breakfast; however, try to learn the best time for the particular patient. Leave the patient in all about 10 minutes; provide privacy, but do not leave entirely alone. Know exactly what the patient is doing; if too preoccupied, keep drawing attention to what is required.

Cleanliness.—Treat the patient as an infant regardless of age; however, psychologically do not consider the patient an infant (this last is important and often difficult). Wash and clean the patient each time the problem arises; better still, try to get him to clean himself.

Confusion in Terms.—Incontinence, untidiness, enuresis, and just plain neglect are terms sometimes confused. Know the differences.

“Incontinence” is lack of control due to organic causes.

“Untidiness” is lack of control due to mental reasons.

“Enuresis” refers to a discharge of urine at night during sleep.

Sometimes a patient is reported “untidy” or “incontinent” when regular toileting would take care of the condition.

Records.—Records should be accurate and include time, amount, character, and also the behavior toward excretory functioning—undue concern or interest, exaggerated or incorrect ideas, handling of feces, or effort to prevent bowel evacuation.

ESCAPE

Responsibility.—The responsibility for the escape of a patient falls primarily on the nursing personnel. A hospital for the mentally ill is not a penal institution; an escape, however, may be a serious matter. It may mean suicide, homicide, death from exposure while wandering, social misdemeanor, or public nuisance.

Common Methods of Escape.

1. **Doors.** Patients hide near exit doors and slip out when the door is opened.
2. **Improvised tools.** Keys are fashioned from spoon handles, screw drivers from table silver.
3. **New employees.** Now and then a new employee is persuaded by a patient to let him through a locked door.

4. Off-ward activities. Activities off the ward, especially going to and from cafeteria, offer chances of escape; when groups are large it is easy to miscount or overlook one patient.
5. Parole. Occasionally ground-parole privileges are violated.
6. Relatives. Not understanding the total situation, relatives do not always cooperate and sometimes help a patient to escape or even allow him to elope with them.
7. Windows. Patients break out of windows; if the window is above the first floor, sheets are used for rope.

Prevention. Nursing care of escape resides chiefly in prevention. The following points are important:

1. Watch all patients for possible escape.
2. Keep an "escape risk" list in the nursing station; as with the suicidal list, keep out of sight even though patients are not supposed to enter the nursing station.
3. Give special attention to patients known as escape risks.
 - a. Do not allow them to leave the ward unaccompanied.
 - b. Do not allow them to leave the building with visitors unless there is a written permission by the physician.
 - c. Watch especially at bedtime, during activities off the ward (cafeteria, church service, entertainments), and when there is any change in personnel or activity.
 - d. Study the habits of patients.
 - e. Examine clothes and quarters regularly for instruments of escape.
 - f. Know hospital limitations concerning the freedom of patients. The ward manual should state where they may or may not go; for example, unless ordered to be kept on the ward, patients may go to activities held in the hospital auditorium or chapel; they are not to go to the library, commissary, or lawn parties without a special order.
4. Be familiar with requirements regarding locked doors.
5. Do not allow anyone without identification to leave the ward.
6. Keep keys secure. It is best to have the keys on a ring and fastened to the uniform; the custom is to use a strong cord (the braided type made by the occupational-therapy department) and attach this to the keys at one end and

- to the waistband at the other—all under the apron; when not in use keys rest in the uniform pocket.
7. Do not use your own judgment concerning personal freedom for nonparole patients; when the patient can be trusted alone, he will be given parole privileges.
 8. Report any remarks pertinent to escape.
 9. Investigate the meaning of restlessness.
 10. Count patients regularly (if the group is small, count by using the patients' names). They should be counted on reporting on and off duty; any group leaving or returning to the ward should be counted; the entire group is counted at bedtime; and a group on outside activities should be counted frequently.
 11. Outside activities require special vigilance.
 - a. In all group activities out of doors, there should be more than one hospital worker.
 - b. One person should carry the particular responsibility concerning possible escapes; in this way the other workers can enter wholeheartedly into all patient activities.
 - c. Each nurse or attendant should know which person is responsible for escapes.
 - d. Count patients frequently; this responsibility may be carried by the person particularly responsible for escapes unless the group is very large, in which event subdivisions of special responsibility have to be made.
 - e. Know not only the number of patients but their names, how they look, and how they are dressed. In the event of escape be able to identify the particular patient.
 - f. Know which patients are escape risks. Some hospitals consider it advisable to use some means of identification such as a red cape, others try to keep such patients in prominent places, and still others group escape risks together and furnish additional workers.
 - g. Scatter personnel throughout the group of patients. The person who is particularly responsible for escapes should remain in the rear or within sight of all patients at all times. This person's particular duty should not be obvious.
 - h. Know hospital boundaries for patients.

Actual Escape.

1. Immediately notify someone in authority—head nurse or supervisor.
2. If alone with a group of patients, move the entire group to the nearest telephone and notify supervisor.
3. If out of doors, follow a patient who starts to run away; this will attract attention.

Records. Hospitals usually use the same record form as for accidents (see page 173).

Return of Patient from Escape.

1. Do not ask questions about the escape.
2. Treat as a newly admitted hospital guest. Readmission routine depends upon the length of time the patient was away from the hospital. Bathe and examine body and clothes at this time.
3. Provide a drink—hot drink in cold weather, cold drink in warm weather.
4. Do everything to lessen tension.
5. Try to get the patient occupied as soon as possible.

For references to books and articles on the subjects covered in this chapter, see list at end of Chap. VI.

CHAPTER VI

NURSING CARE: SPECIAL PROBLEMS, CONTINUED

The special problems in nursing care discussed in the previous section were accidents, aggressive behavior, elimination, and escape; those considered in this section are (1) nutrition, (2) relatives, (3) seizures, (4) sleep, and (5) suicide.

NUTRITION

Refusal of Food.—Many patients in hospitals for the mentally ill refuse to eat. This presents an important and very difficult nursing problem.

Course of Action.—When a patient will not eat, the course of action is, first, to review reasons why patients do not eat and to investigate the reason for this particular patient, speculating on indirect influences. The exact problem must then be formulated and potential approaches outlined. Finally, it is necessary to analyze the total situation as to effort, negative results, and positive results. (See discussion of nursing activities extending over a long period, page 17.)

Some reasons why patients do not eat are the following:

1. Symptoms of illness.
 - a. Confusion; delirium.
 - b. Delusions, *e.g.*, that the food is poisoned, that the patient has no stomach or no bowels, that he is unworthy, that he cannot afford to buy food, that others will starve.
 - c. Distressing emotion, particularly depression or agitation—when a deeply depressed patient has not eaten for 2 days he is not likely to resume spontaneously.
 - d. Fatigue.
 - e. Hallucinations, *e.g.*, he is told not to eat.
 - f. Indecision.
 - g. Lack of initiative.

- h. Loss of appetite—there may be changes in the digestive tract, diminished secretions, feeling of fullness in the stomach.
 - i. Overactivity—the patient is too busy.
 - j. Preoccupation.
 - k. Self-denial.
 - l. Suicidal intent.
 - m. Symbolization—sometimes certain foods are symbolic, that is, they stand for something else.
 - n. To gain attention.
- 2. Rational reasons.
 - a. Bad taste in the mouth.
 - b. Poor teeth.
 - c. Certain likes and dislikes.
 - d. Existing allergies.
 - e. Religious reasons.
 - f. Seasoning.
 - g. Sensitivities regarding preparation and service.
 - h. Temperature.

The refusal of food is an individual matter. The problem stares one in the face, but it cannot be met intelligently until viewed in relation to the patient at hand. Patients do not eat for this or that reason, but the piercing question should be "Why does this particular patient not eat?"

Sometimes the patient will give the reason, although often it is not the real reason. Always you have to observe and interpret what takes place. Formulate questions born of your own experience:

Is the reaction temporary or fixed?

Is the patient comfortable physically? Emotionally?

Does he have enough time? (And that does not mean that 20 minutes is enough time for everyone; but, how long does this patient need?)

Is he lonely?

Are there too many people around?

Is he unhappy with his immediate neighbors?

What is his attitude toward food? Toward the need? Should it be changed? Have I tried to change it? In what ways?

Am I getting results?

What do I know about this patient as a person? What are his likes and dislikes as to food, preparation, and service?

Does he show a preference for a particular food? Does this throw any light on the problem?

Am I more successful today than yesterday? This week than last week? Why? Am I less successful? Why?

Do I think more about the result or the effort?

Am I sufficiently interested?

What methods seem to be most productive?

Do I watch for changes and variations in mood?

Is there a positive correlation between appetite and any special behavior?

Are there any points of similarity or difference: When the patient does eat, are there any identical items—kind of food, preparation, service, environment; container; people around at the time, any particular person, the absence of others; the mood on waking; the amount of relaxation during rest period; the behavior of others on the ward; my own general attitude and behavior?

Indirect influences on the problem are fresh air, exercise, proper elimination, and satisfying environment, particularly the dining room and the spirit associated with the mealtime.

The dining room should be an attractive, pleasant place, and for those who are disturbed it should serve as a definite and worthwhile behavior goal. In choosing a dining room attention should be paid to the location, size, ventilation, light, and view from the window. The furnishings should be attractive and colorful. The tables should be small to take care of six to eight patients, and chairs should be comfortable. Flowers make a pleasant addition. Have those that are colorful and sweet-smelling if possible; just a few on each table are better and more easily obtained than large bouquets for a mantel piece. Do not use only cultivated flowers; wild flowers are always lovely, and many weeds are beautiful. There should be no rattling of dishes, and kitchen odors are always distressing. As for the general atmosphere, the people are responsible for this. The attitude and behavior of the nurse should be that of hostess. Employees should be clean, kind, and pleasant. Patients who are congenial should be placed near each other; conversation should be cheerful. The hospital workers may need to

stimulate and guide the conversation, but they should endeavor to make the patients happy with each other.

All of the hospital dining rooms cannot be equally attractive and well-furnished, as the general group behavior may not permit. From a standpoint of health the dining rooms for the convalescent and quiet wards should be patterned after the best form.

Spirit of Mealtime.—A meal should be a pleasant occasion. Congenial companions should be seated near each other—congenial from a standpoint of age, conversation, speed in movements, and state of health. Pay attention to dress and general appearance.

Patients should make preparation for meals—wash hands and face; comb hair; if necessary, attend to body odors. See that the patients have enough time to make the necessary preparations. Reduce activities about one-half hour before meals. Pay special attention to those who tend to be tardy.

Make certain meals important. Dress up for Sunday dinner, notice birthdays with birthday cakes and the "fixings," celebrate holidays. On these occasions bring in the candles, prettiest dishes, extra flowers, elements of fun and surprise. Decorate on such days as Christmas and Thanksgiving.

Have an occasional meal as a picnic on the hospital lawn. Share treats from home, such as a box of cookies. How much this is done depends on the amount of food and the number of patients. Now and then end the meal with a piece of candy for everyone, the candy having been prepared in the diet kitchen.

The Exact Problem with Specific Approaches.—The central problem is presented by the fact that the patient will not eat, but this is only the starting point. When you know the reason, you have something definite on which to work. Some exact problems with suggested specific approaches are the following:

1. Bad taste in the mouth. Pay attention to oral hygiene; investigate the need regarding a dental examination; look into the physical condition, especially the possibility of constipation.
2. Delusions of poison. Give food untouched by others, such as baked potatoes, whole fruit, eggs in shell; have the patient see that all are fed from the same container; with a separate spoon taste the patient's food in front of him.
3. Delusions of unworthiness. Leave the patient alone with the food—he will probably eat some when unnoticed· do not discuss the matter.

4. Existing allergies. Learn which foods; the patient will know.
5. Feeling of fullness. Give small portions, frequent servings.
6. Hallucinations. These are not continuous; watch opportunities and give extra nourishment at free times.
7. Indecision. Reduce the possibilities for choice; serve only one article of food at a time.
8. Lack of initiative. Begin to help the patient feed himself, actually setting the body mechanics into action; but do not go off and leave the patient as soon as he takes a mouthful by himself—probably such a start will continue only for a few mouthfuls.

Analysis of the Total Situation.—It is unusual for any one nurse to be successful every time or with every patient. Fortunately this is secondary in importance to what is accomplished in the course of a few weeks and by the group. To this end, analyze the total situation from time to time as to your effort, negative results, and positive results. For developing your mental equipment the analysis of positive results is just as important as the analysis of negative results; in other words, when the ultimate goal is reached you need to understand *why* and *how*.

Additional Problems.—The refusal of food is not the only problem. Whatever the problem, always look for the reason. A few outstanding problems with suggestions for their solution follow.

Asocial Behavior.—Some patients are untidy and spit out food, others snatch food from other patients' plates, and still others show odd behavior that is not pleasant to those around them. While the behavior is such, the patient must eat alone.

If the patient throws food, serve meals in courses, give small amounts, and attempt to have the patient clean up the food he has thrown. Notice whether he throws away all foods or just some particular food. The behavior may be for so simple a reason as a dislike for a particular food.

When table manners are poor, look for the reason. If the patient lacks training in such social matters, tactfully help him to learn nicer ways and provide suggestion through an association with those of good table manners.

Situations like these are dealt with realistically. The patient is told what is objectionable, why it is objectionable, the price he has to pay, what is desired, and the accompanying rewards. An important nursing responsibility is not to view the behavior as

permanent. Expect more of the patient—give opportunity to show improvement, and encourage and recognize advancement.

Choking.—When the patient chokes easily, remove bones, shells, and fruit pits, as they have a way of sticking in the throat. Give special attention to elderly people and to those suffering with syphilitic meningoencephalitis (general paresis).

Excessive Use of Beverages.—Some patients are heavy coffee and tea drinkers; when this is so, inform physician of actual situation; the amount may have to be limited.

Hoarding.—If the reason for hoarding is to appease hunger, especially when the evening meal is served early, see that the patient is given something to eat before retiring along with those who need extra nourishment because of undernourishment. If hoarding is a symptom of illness, limit available space and provide constant supervision. Food should not be left around the patient's quarters because it makes for untidiness and draws insects and mice.

If the patient has fruit of his own in the icebox, see that he has an opportunity to eat it.

Overeating.—Occasionally a patient eats too much. Try to help the patient do a better job at chewing. The amount of food given may have to be limited, but this would be only by a physician's order; keep the physician informed as to the actual condition.

Speed.—Many patients eat too fast. In such cases endeavor to slow the speed; have the patient chew longer; serve in courses and in small amounts; try to get the patient to talk more.

Fluid Intake.—Sufficient fluid intake is necessary to restore general health. In the hospitals for the mentally ill, patients usually do not take enough fluids. This is an important nursing responsibility and should not be haphazard or left to chance. Establish a schedule—once in the middle of the morning, two or three times during the afternoon, and once in the early evening. If possible give fruit juices or fruit ades. Pay particular attention to patients following admission and to those who are constipated or overactive.

For patients who are underweight and are having extra nourishment, the drinks can be eggnog and milk shakes, served with cookies or sandwiches. For overweight patients water only should be given between meals and this may need to be limited; consult with the physician.

Feeding a Patient.

1. Pay attention to the patient's position; see that he is comfortable.
2. Consider the order in which the patient might like the food — solids, liquids, particular dish.
3. Do not overlook niceties in giving the food — the use of the fork or spoon, thoughtfulness, companionship.
4. Frequently provide a chance for the patient to take over by himself (if his physical condition warrants).
5. Give plenty of time.
6. When drinking tubes are needed, use a drinking cup or a straw tube, never glass.

Forced Feeding.—The writer is of the opinion that the results of forced feeding do not justify the procedure. At best the amount of nourishment given this way is not enough, and, being a form of coercion, the procedure presents the danger of increasing inner antagonism. Never force a patient to eat unless under the direction of a physician.

Undernourished Patients.—Orders for undernourished patients usually specify supplementary feedings (high-caloric lunches, extra nourishment), high caloric diet, insulin (20 to 30 units $\frac{1}{2}$ hour before breakfast; this is a nonshock dose), or tube feeding (since the advent of electric shock, tube feedings have been reduced to only an occasional special case, although electric shock is not given primarily for undernourishment).

Weight.—The weight of all patients is closely watched. Know what the patient should weigh and draw the physician's attention to any specific loss or gain or general tendency. Keep the record of weight up to date. Weigh patients according to hospital routine —every day, once a week, once a month, depending upon the particular treatment unit.

RELATIVES

Importance of the Problem.—Relatives are often trying, but they affect the patient's emotional state and are a force to be reckoned with in nursing care.

Reasons for Difficulty.—Relatives of patients in hospitals for the mentally ill feel helpless, confused, and defiant chiefly because

they rarely understand *anything* about the patient's condition, they have no knowledge of the cause and nature of the illness, and they do not appreciate the significance of their own behavior in the total situation.

Important Nursing Points.—It is well to keep the following points in mind: The patient's relatives are emotionally upset. Often they do not agree among themselves. They have feelings of guilt in regard to the patient's presence in the hospital that arise from a clash between a desire (motivated by duty and love) to keep the person at home and a dread of his presence there because he makes life so difficult. They have feelings of guilt, also, because people in general speak against institutions for the mentally ill. These feelings of guilt are projected onto the hospital and staff as seen in defiant attitudes and attacks on the adequacy of treatment and care. Questions asked by relatives usually require answers that reach into the unknown. The nurse should refer them to the physician for information on all matters that relate to the illness—cause, course, and prognosis; every additional person who gives information increases the possibility for misinterpretations and accompanying difficulties. The relatives leave the loved one (the patient) in the care of strangers. Remember that you are a kind of buffer between the relatives and the patient. If the hospital has information for patients or relatives (printed letters or mimeographed material), be acquainted with this and use the same ideas in talking with relatives.

Unpleasant Situations.—Frequently relatives are not permitted to see the patient, especially a particular relative who is a contributing factor in the illness. This is something a relative rarely understands or accepts. You must be careful to refrain from making any attempt to throw light on the true situation; the physician will meet or provide for the need. In such cases your duty is to support the physician in his judgment of what is best for the patient.

Matters relating to the patient's clothes present difficult problems with relatives. It is hard for relatives to appreciate two things, namely, that the wear and tear on clothes is just as great for the person who is mentally ill as with a well person, greater if the patient is destructive; and that so many clothes are necessary. A large supply of clothes is needed partly because of the patient's behavior but chiefly because of the length of time that it takes

for clothes to be returned from the laundry, making it necessary to have more clothes in circulation than some people are accustomed to at home.

Know the exact situation regarding a patient's clothes—what he had on admission, what has been added since admission, what is on hand, what the patient needs—and be able to account for loss through clothes worn out or destroyed by the patient. This information should all be recorded on the ward clothes record. In asking for clothes, either directly of relatives or through the social service department, appreciate that it may be a simple matter for one family to supply half a dozen pairs of hose but a hardship for another to provide two pairs.

Evaluate Relatives.—For further information on the patient's life and problems evaluate relatives when in contact with them. Estimate their intelligence, education, culture, affection toward the patient, and outstanding characteristics.

Special Consideration.—Relatives of patients have strong feelings and memories. Frequently you are the first hospital worker with whom they talk over personal problems. These occasions present opportunities to influence the feelings of these people. Through thoughtfulness and tact you can communicate the extended hand of the institution and change feelings of dread and hostility to those of welcome.

Often simple measures work wonders with the feelings of a relative. Several years ago there was a paragraph or two in the *Trained Nurse and Hospital Review* entitled, "Here, Let Me Help with That Suitcase." The general idea was that a hospital worker, seeing a woman approaching the entrance and struggling with a man and a suitcase, hustled out to meet her and greeted her as stated above.

Mr. S. was the father of a patient and a very difficult relative. One day he was sitting by the front door as a student nurse entered the hospital. Thinking the man looked like Bernard Shaw, she paused a moment, went over to him, put out her hand, said, "How do you do, you look like a distinguished gentleman," chatted a moment, and went on her way.

The more difficult the relative, the greater his inner distress. When relatives are especially trying, appreciate that their behavior is all tied up with the patient's illness and their own helplessness and feelings of frustration. You have the advantage over the

relative because you understand the total situation, and for this reason alone you can afford to be generous at all times and on all occasions.

SEIZURES

Seizures are seen quite frequently on psychiatric wards.

Symptom.—A seizure is a symptom. In observation watch particularly for temporary loss or impairment of consciousness, sudden appearance of the seizure, and recurrence.

Occurrence.—There are some eighteen pathological states in which seizures occur. They are found mostly in organic conditions in which there is a defined disease or a change in structure (see discussion of secondary personality changes, page 259). A condition allied to seizures is found in the primary personality disorders, particularly hysteria.

Nursing Responsibility.—Outstanding nursing responsibilities are to report an accurate description of the symptoms (exactly what takes place, the order in which events occur), to help a person subject to seizures to live as normally as possible, and to keep such a person away from potential dangers—climbing a ladder, working over a hot stove or furnace, using sharp scissors (provide blunt scissors, wood or bone crochet hook, etc.). Keep radiators covered; watch the patient going up and down stairs; attend the patient during bath because of the danger of drowning or falling and hitting himself against equipment that projects.

Types.—There are two main types of seizures, grand mal (major attack) and petit mal (minor attack).

Grand Mal.—A grand mal is the classical seizure of idiopathic epilepsy (see description of psychoses due to convulsive disorder, page 282). The distinguishing features are aura, tonic phase, clonic phase, and postseizure period.

The aura is a sign previous to the actual attack. The *prodromal aura* is a sign or symptom that appears several days before a seizure, such as insomnia, restlessness, emotional changes, sexual desire. The *immediate aura* is a subjective warning that occurs just before the seizure; the patient usually screams and immediately falls to the ground. The immediate aura usually consists of a sensory experience—taste, odor, flash of light, noise, deafness, anger, fear, rapture, dizziness. The patient sometimes breaks out in perspiration, and the face becomes pale or flushed.

In the *tonic phase* there is sustained contraction of muscular tissue; this lasts only 10 to 15 seconds. The symptoms include: muscular rigidity (chest is fixed); respiration ceases until the gasp at the end of the seizure; face is engorged (the color is at first purple, then changes to a bluish purple (cyanosis), and then to pallor); pupils are dilated and do not react to light; and incontinence (urinary) is common.

In the *clonic phase* there is alternate contraction and relaxation of muscular tissue. Symptoms include: alternate contraction and relaxation of muscles (contractions soon decrease in number and force); tongue may be bitten; frothing at the mouth (saliva is mixed with air); and movement of lips, hands, and arms.

The *postseizure period* immediately follows the attack and is usually one of sleep or violence with amnesia. Following a seizure the patient usually sleeps; on awakening he is confused, often disoriented, and complains of headache and muscle soreness especially to pressure. When a psychosis is present, the behavior following a seizure is often violent and destructive; it is unwise to touch such a patient as he is regaining consciousness. Be alert to the possible overactivity and have help in the immediate vicinity. Following a seizure the patient has amnesia for the attack.

Petit Mal.—The petit mal is much less dramatic than the grand mal and, unless the patient is being observed closely, may not be noticed. The outstanding characteristic is that the face is pale, the eyes stare, and all activity is suspended for a few seconds. Loss of consciousness is only a matter of seconds, and the patient rarely falls.

Tests for Sensitivity to Seizures.—Sensitivity to seizures is tested by the following methods: If a patient is sensitive to seizures, *hyperventilation* for a few minutes will induce a petit mal. Again, if a patient is sensitive to seizures, *hydration* (forced fluids, 3,000 to 6,000 cc. a day and injections of pitressin, 1 cc. every 2 hours) will usually cause a convulsion within 48 hours.

Nursing Care.—Nursing care includes the observation of the seizure as well as the actual care.

Observation of Seizure.

1. Establish unconsciousness. If the patient is unconscious, the pupils are dilated and do not react to light, very likely there is incontinence, and the patient is insensitive to painful stimuli.

2. Have definite points in mind.
3. Know the total length of the seizure, from the scream or fall to the gasp for breath.
4. Be alert to maniacal behavior following seizures.

Outline for Detailed Observation. The following outline is presented as a guide to important points to be covered in observing seizures. It is not possible to remember all details with each seizure, but after recording the observation of a seizure make a mental note of particular details for which to watch during the next seizure.

1. The consecutive number.
2. The time.
3. The aura. This is obtained from the patient after he regains consciousness.
4. Cry.
5. Fall.
6. First part of body convulsed.
7. Loss of consciousness—dilated pupils that do not react to light, incontinence, insensitivity to painful stimuli.
8. Pupils dilated—right, left, both.
9. Tonic convulsion—parts involved (all muscles or just a group of muscles), duration.
10. Clonic convulsion—parts involved, duration.
11. Frothing at mouth.
12. Tongue bitten.
13. Stertor (snoring).
14. Cyanosis—degree, extent.
15. Perspiration.
16. Duration of entire seizure.

Additional Observation Expected.—The following points are also important:

1. What was the situation or circumstance just previous to the attack? Were people around? How many? Who?
2. Did the attack occur at night? During sleep?
3. If the jerking and twitching were confined to a particular part of the body, exactly what part?
4. If the eyes rotated to one side, which side?

5. Was there any peculiar behavior just before the attack? Following seizure?

Care During Seizure.

1. Do not move the patient; let him lie flat on his back on the floor.
2. Place an object not too big to be swallowed (mouth gag, rolled paper) between back teeth on one side of the mouth to prevent gnashing; do not attempt to force the jaw open during tonic phase, as it is easy to break a tooth. It is useless to try to prevent gnashing after the seizure has begun.
3. Turn head to one side to prevent aspiration of saliva with the gasp at the termination of the seizure.
4. If the seizure occurs during a meal, place the head lower than the body if possible, or turn the head on one side to keep fluids and food out of the breathing passage.
5. Prevent injury to the head; use any convenient garment.
6. Loosen clothing, especially around the neck.
7. If the seizure occurs at night, be very careful that the face is not covered because of the danger of suffocation.

Care Following Seizure.

1. Move the person to a room where he can rest.
2. Know that he is clean and dry.
3. Supervise until mentally clear.
4. Be alert for possible maniacal behavior.
5. Examine for injury.
6. Watch for depression.

Physician's Differentiating Diagnosis.—In patients with primary personality disorders, particularly the psychoneuroses, sometimes seizures appear as a symptom of illness. In such cases the physician needs to eliminate the existence of idiopathic epilepsy or positive organic pathology and depends very much on the nursing personnel to give an accurate report of seizures. From this particular angle the points given in Table 2 are of special interest.

It should be appreciated that the two conditions—convulsive seizures and psychoneurosis—can exist in the same patient.

TABLE 2

	Classical seizure	Psychoneurosis
Consciousness	Loss of consciousness Pupils do not react to light Incontinence Definite pattern based on physiology or pathology	The patient knows what is going on around him Pupils react to light Does not wet self No pattern
Movements	Frequent; gets hurt in the fall; bites tongue	Rare and not serious; falls in "soft spots"; may chew at lips but does not bite tongue
Injury	Before actual seizure Any time; total length of time is only a few seconds to 2 minutes	During seizure Not during sleep; total length of time is longer than 2 minutes
Scream	Abnormal characteristic	Normal
Time		
Electro-encephalogram		

SLEEP

Value.—Sleep relieves the mind of conscious problems and restores bodily energy. It is a sedative and also the best of stimulants.

Nursing Responsibility.—Being a regenerative process, sleep is an important universal therapeutic measure, and on a psychiatric ward the responsibility is placed heavily on the nursing personnel.

In a general hospital the responsibility for the patient's sleep is not placed on the nursing service; that is, a nurse is not praised when a patient sleeps or blamed when he does not. Usually the illnesses are acute and of short duration; sedatives can be given safely. For those who are mentally ill the situation is different. It is here that nursing skill meets its greatest test, and an outstanding standard for judging the quality of nursing care is the sleep a patient gets without sedation.

Nursing measures for promoting sleep are the same for all patients; with those who are mentally ill the problem is especially difficult, however, and yet more is expected of the nurse.

All simple nursing measures have to be reviewed in entirety night after night and carried out with confident assurance that some sleep will follow. Although the full burden of any illness is most heavy at night, nursing care regarding sleep is not confined to a particular procedure at bedtime. Your special field relates to environmental situations (particularly the "smaller vexations of life" for which John Stuart Mill, in his "Autobiography," said that sleep is the "sovereign remedy"). Sleep is an indication of nursing success in lessening emotional tension and in reducing negative attitudes during the day. (See discussion of evaluation of care, page 255.)

Rest.—At night, sleep and nothing less is the goal, but during the day many patients need definite periods of rest. In general, old people should have a short period of rest in the morning and during the afternoon; people who are not physically strong need to let up on activities; overactive patients need a "letdown." Ward routines or physician's orders will establish actual rest periods.

If opportunity for rest is not provided, be especially alert to the signs of beginning fatigue: impatience, flushing of the face, inability to fix attention. Fatigue increases mental manifestations of illness.

Not all hospitals schedule a rest period following lunch, but this is a ward activity that noticeably helps the general behavior and the actual control of the patient, even the excited patient. During such a rest period patients should undress and go to bed; the windows should be opened, the window shades lowered, and everything conducive to quiet should be maintained. Nurses and attendants should not go in and out of the ward at this time or move about on the ward. A nurse should be stationed among the patients and should remain alert but quiet.

Specific Duties.—The nurse's specific duties are to promote relaxation and sleep, to know the cause of sleeplessness and specific nursing measures, to know the amount of sleep in each 24 hours, to know the quality of sleep, to know the sleep pattern or rhythm, to keep records, and to have information on medications used—type of drug, dosage, any peculiarities of administration, approximate length of time for effect, and symptoms of overdose.

Promoting Sleep.—Promoting sleep in a patient is closely related to the central nursing objective, namely, to make the patientulti-

mately more comfortable, especially from an emotional point of view. With this in mind, you should appreciate that your responsibility is not tied up in a single nursing activity and that results come only from a continual effort to develop effective interpersonal relationships—the initial nursing objective and the primary nursing procedure.

When you deal with a sleepless patient, think a minute about the story of Jupiter creating Sleep, as recounted by Walter Pater in "Marius the Epicurean": At the beginning of the world Jupiter divided time into two parts, day and night. Day was for work and night was for quiet, but gradually more and more business was carried on into the night. To protect man Jupiter created Sleep. Sleep was a member of the gods and was to have charge of human eyes. Jupiter himself prepared the potion with which Sleep was to soothe the world. The ingredients were juices from the herb of Enjoyment and the herb of Safety and one single drop, no bigger than a tear, from the herb of Death. Then Jupiter gave Sleep wings, not fastened to his heels like Mercury's, but to his shoulder, like the wings of Love. For he said, "It becomes thee not to approach men's eyes as with the noise of chariots, and the rushing of a swift courser, but in placid and merciful flight, as upon the wings of a swallow—nay! with not so much as the flutter of a dove."

Causes of Sleeplessness and Nursing Measures.—With those who are mentally ill the principal causes of sleeplessness are emotional turmoil, inner tensions, anxiety produced by conflict. You cannot remove the patient's problem (chief complaint), but you can contribute greatly to a superficial, temporary state of peace.

In general, the causes of sleeplessness can be divided into (1) physical, (2) mental, and (3) environmental.

The *physical* causes relate chiefly to physical discomforts and inadequate muscular relaxation.

Physical discomforts such as pain, indigestion, cough, dyspnea, or diarrhea are probably the most common causes of sleeplessness with patients who suffer predominantly with a physical illness; however, in a hospital for the mentally ill these discomforts are not common. When they occur they are treated and cared for the same as on a medical ward.

Muscular relaxation is an essential precondition to sleep and is a common need on the psychiatric ward.

Your most effective tool for producing relaxation and sleep is the simple, almost elementary back rub. Have you learned this? And in giving a back rub how often is sleep the objective?

A back rub that relaxes the patient sufficiently is a special and consuming effort. The secret for success lies within yourself. Your starting point is the preparation for sleep and the actual technic of a massage of the back as taught in the classroom, but in practice you must catch the significance of factors such as suitable environment and the absence of conversation. You should know the value of smoothness in movements and sense the time for strong and light touch. You should understand the soothing effect of the long downward strokes and the special attention required on the neck, between the shoulder blades, and along the vertebral column. Your own state of emotional serenity (transfer of feeling tones) is an important factor. The total length of time for the back rub is half an hour to an hour.

A back rub that results in sleep cannot be given to every patient every night. There is not enough time, you would not have sufficient energy, and besides, every patient does not require such a back rub. This kind of back rub is given to meet a specific need and is not a routine part of evening care. If there are several patients who would benefit from this kind of care, concentrate on different patients different nights or different patients at different times. For example, give such a back rub early to the patient who has difficulty in getting to sleep; give the back rub later to the patient who goes to sleep easily but wakes up in a few hours.

Would that every nurse could know her potential nursing effectiveness regarding sleep for a patient in so simple a measure as the back rub!

Other measures for body relaxation are useful activities during the day which provide satisfaction and earned fatigue, proper and sufficient exercise, and baths. Sometimes a continuous bath is ordered at hours of sleep; when such a bath is given, the patient should be put to bed immediately, covered, and kept away from drafts. If a continuous bath is not ordered, an ordinary sponge bath, a little on the cool side, may soothe a restless patient. A warm drink is also of value, especially hot milk.

Regarding *mental* causes of sleeplessness, the principal factors are fears and anxieties. Fear keeps the person in a state of alertness ready for defense; this is incompatible with sleep. The pro-

vision of safety, especially immediate safety, is your guide in putting a fearful patient to sleep.

Many of the patient's fears are an intrinsic part of the illness and cannot be dealt with directly by nursing measures; there are fears of a more superficial nature, however, that are within your immediate province. Unless probed a little, patients will not discuss these fears that are near the surface lest they appear silly, childish, weak, or cowardly. Some such fears are:

1. Fear about sleeplessness. Most patients who cannot sleep are sure that the sleeplessness leads to insanity, brain deterioration, or suicide. Since the facts do not support the general idea, it is possible to reassure the patient and dispel doubts of the grave effects. Then the nursing task is to influence the patient to adopt a more healthful mental attitude.
2. Fears relating to environmental factors, particularly with the newly admitted patient. On admission the patient is brought into contact with unfamiliar factors—novel surroundings, strange bed, unusual noises, possibly unaccustomed silence; these foster fear. Endeavor to orient the patient to his surroundings as quickly as possible and especially before any immediate need. The very first day in the hospital the patient needs information on ward activities—the immediate hospital routines, of what they consist, why and how carried out, what kind of noises will occur, the location of the toilet, the matter of lights, what nurses and attendants will be on duty at night, where they will be stationed, when they go to midnight supper, and who is in charge at night. Even if the patient does not remember, a note of recognition may come when the new situation arises.
3. Fears about being a nuisance. Some patients are afraid to disturb or bother the night nurse. Patients who are unaccustomed to hospital life invariably address the night nurse thus: "I am so sorry to get you up." Be sure the new patient knows that night nurses rest and sleep in the daytime and are on duty at night expressly to take care of the patients' needs.
4. Fears concerning the height of the bed. A hospital bed is usually higher and narrower than home beds, and many a patient does not sleep the first few nights for fear of falling

out of bed. Until the patient is used to the bed, if necessary move the bed to the wall for the night or place a chair or two in front of the bed; have bathroom slippers on the lower part of the bedside table—not on the floor to add to the patient's awareness and discomfort concerning the height of the bed; assist the patient in and out of bed until he is accustomed to the height. Some hospitals for the mentally ill have beds more in keeping with home beds and have the hospital type of bed only on wards housing patients who are ill physically and need much bedside care.

5. Fear of soiling the bed. Sometimes the nervous patient is afraid of wetting the bed and of the embarrassment that follows. Let the patient who goes to the toilet frequently, or who has a history of bed wetting, know that for the present there is a rubber sheet to protect the mattress, and that if an accident does occur there is no harm done and the difficulty is understood.
6. Fear of changing position. Now and then a patient lies in a position that is uncomfortable for him because he is afraid to change the bed situation as presented to him; for example, he may be lying flat on his back with his head raised on two pillows and yet he wants to discard the pillows and turn on his abdomen. Find out in what position he habitually got his best sleep at home or when he was well.
7. Fear of being left alone. Occasionally a patient is unable to sleep for fear of being left alone. Assure such a patient that a hospital worker is in the ward all night. To give further assurance pause a few minutes now and then at this patient's side; do not talk—the assurance will come from the mere presence of an interested person. Sometimes a short visit with pleasant relaxing conversation, especially in the early evening, is just what is needed to get the patient's mind off himself and his loneliness.
8. Fear of pain and death. In the minds of many patients hospitals are associated with pain and death. In a hospital for the mentally ill physical pain is unusual, and until fairly recently deaths have been comparatively few. During the past few years the large hospitals for the mentally ill are more and more having to meet the social problem of old age, and large numbers of patients over seventy are being admitted.

Many of these people are moribund on admission and die within a few months. When patients fear pain or death, an opportunity is provided to educate concerning the full function of a hospital. Hospitals are established primarily for the restoration of health. The main function of the hospital is to help patients learn how to be successful—to enjoy a fair relationship between potential abilities and capacities and constructive productive activities; to be efficient—to utilize inborn capacities to advantage for self and others; and to be happy—to have peace following the resolution of inner tensions. Dr. C. C. Burlingame of Hartford, Connecticut, significantly calls the hospital under his direction "The Institute of Living."

9. Fear that sedatives will become a habit. A few patients are afraid that taking sedatives will become a habit. When this problem arises, assure the patient that he is protected, as the drugs are given under qualified supervision.

A patient who is afraid will be restless, irritable, and troublesome at night. What provides peace of mind will produce sleep. When the patient is very ill, a ward atmosphere that radiates serenity, kindness, and personal strength can do wonders in reducing immediate fears. When the patient is getting better, useful activities tend to direct thinking away from self and provide inner satisfaction, particularly that of having a productive, serviceable place in the world.

The *environmental* factors that influence sleep relate to such matters as the following:

1. Appreciate that even in sleep there is an awareness of things that threaten security, *e.g.*, an unusual though slight noise within the room is more disturbing than a loud noise outside.
2. Pay attention to the weight as well as the warmth of blankets; realize that what is under the patient is just as important as what is over him.
3. A patient should not be neglected, but stimulating conversation should be avoided. A few minutes' chat in the early evening has a soothing effect with some patients.
4. Lights should be subdued. Notice lights in the room, reflected lights from a hall, the street, or passing automobiles; early morning sunlight and even light from the moon may

- disturb a patient. If a flashlight is used on the ward, do not put the light directly on the patient's face; learn to use it skillfully with the central beam toward the floor and the patient's face seen in the peripheral glow.
5. The mattress should be dry and smooth. For a feeling of security even so simple a thing as having the mattress close to the head of the bed is important.
 6. Unnecessary noise should be eliminated. If a neighboring patient snores and keeps a patient awake, it is usually possible to make the needed adjustment by moving one of the patients; place the patient who snores beside one who has a hearing defect or who sleeps soundly.
 7. The room temperature at night should be 65° F. or lower. The exact temperature depends on the age of the patient, the general physical condition, and how frequently the patient gets up in the night.
 8. Ventilation is important not only at the time of retiring but during the entire night.

Amount of Sleep.—It is important to know the amount of sleep which the patient gets in each 24 hours and the amount of sleep for several consecutive 24-hour periods. The optimum quantity of sleep in 24 hours is $6\frac{1}{2}$ to 8 hours.

The patient's ideas on how much he sleeps are not dependable. People do not estimate time accurately when awake and trying to sleep; also, people look upon a lack of restful sleep as a lack of sleep. The best way to estimate the quantity of sleep is to keep a ward sleep chart, whether or not the hospital routine calls for such a chart.

The following points should be observed in keeping a sleep chart such as the one illustrated on p. 216:

1. If the hospital does not furnish a set form, use one anyway; keep several copies on hand, making them out during a lull in the night's activity. Making the blocks square on the chart simplifies ruling.
2. Arrange the patients' names in order of ward residence; this helps you to recognize quickly whether anyone is missing.
3. Make rounds and see each patient every half hour; check whether asleep (✓) or awake (✗).
4. Around 6:30 A.M. total the amount of sleep.

5. At best this record is only an estimate, but it is more exact than the patient's subjective account or your conjecture.
6. A regular check of this kind is especially valuable in the care of suicidal patients.
7. As given here, the ward sleep chart is not a permanent record and may be discarded as soon as the hours of sleep are recorded on the patient's individual chart.

Sleep Chart											
	P. M.			A. M.						Ward	<i>W₁</i>
Nov. 24, 1945	9	10	11	12	1	2	3	4	5	6	Total Hours
John Doe	X	V	X	X	V	X	V	V	V	V	7
Tom Brown	V	V	V	V	X	V	V	V	V	X	6
Jack Jones	X	X	V	V	V	V	V	X	X	V	
Roy Smith	X	X	V	V	V	V	V	X	V	X	
Harry Todd											
Henry Spear											
Norman Stone											
Ray Conner											

FIG. 8.

Quality of Sleep.—It is very important to know the quality of the patient's sleep. Important points to be observed on the quality of sleep are the following:

1. Body movements. Is restlessness continuous? Occasional? Associated with noise? What is the nature of the body movements? What parts of the body are affected? Are movements on one side more exaggerated as compared with the other side? Observe movement not normal in a well person, such as the continued movement of the head or one arm, or upon changing position in sleep. (The assumption is that the fewer the movements the deeper the sleep; this of course is not true in the case of stupor.)
2. Tension. Is there muscular tension as shown by tight fist, knitted brow, clenched jaw?

3. Light sleep. Does the patient sleep fitfully? Is he easily awakened?
4. Sound sleep. Are muscles relaxed as shown by easy posture, deep and quiet respiration, slowed pulse, no response to outside stimuli?
5. Deepest sleep. Is the deepest sleep during the first few hours? Toward morning?
6. Additional items. Notice definite position assumed. Concerning dreams, what is the type? Is there repetition? Upon awakening is the patient refreshed? Fatigued? Note also incontinence, the number of times the patient goes to the toilet, and any reversal of diurnal arrangement. If the patient talks in his sleep, are there any definite trends?

Sleep Pattern or Rhythm.—A sleep pattern is the characteristic way of sleeping and relates to whether the person falls asleep easily or with difficulty, falls asleep easily but wakes in a few hours and is unable to go to sleep again, wakes intermittently, is awake at definite hours, *e.g.*, 1 to 3 A.M., or wakes early in the morning, *e.g.*, 5 A.M.

The nurse should know what the sleep pattern is, know how it deviates from the pattern of the patient when he was in a state of health, and appreciate that the sleep rhythm is influenced by excitement—visits by relatives, holiday activities, and controversies with attendants or other patients.

Records.—A record is always made on the hours of sleep each night for each patient. Know that the record is as accurate as possible, and never grow careless regarding this responsibility.

Sedative Drugs. Important Nursing Points.—Accurate observation on the patient's sleep is the physician's guide to drug therapy. The administration of drugs depends on the amount of sleep, and the choice of a drug depends on the sleep pattern. A change of drug depends on the effect on the patient.

In giving the patient a sedative, when the exact hour is not set by the physician know the approximate length of time for the effect of that particular drug. For example, if a quick-acting drug such as paraldehyde is ordered "if needed," you can afford to wait a little longer to see whether or not the patient is going to sleep than if a slow-acting drug is ordered.

The same drug is not usually used for several consecutive days; rarely longer than one week at a time.

Type of Drug. Sedatives are given to lessen pain (morphine, codeine, aspirin), to reduce muscle tension (phenobarbital, hyoscine), and to reduce mental tension (bromides, chloral hydrate, paraldehyde).

Opium and its derivatives are habit-forming. These are used to lessen pain but only in illnesses of short duration or for pain associated with an incurable disease.

Regarding sedation in a hospital for the mentally ill, drugs used are those that act chiefly on the central nervous system, namely, barbiturates—barbital (veronal), sodium amyta, phenobarbital (luminal); chloral hydrate; and paraldehyde.

Bromides reduce mental tension but are used very little except in combination with another drug such as a barbiturate. If bromides are used, watch for skin eruption; unsteady gait; slurred, imperfect speech; slight memory defect; confusion.

Many patients come to the hospital with a psychosis due to bromides superimposed on the initial mental condition; the condition is serious when bromides in the blood reach 150 mg. per 100 cc. Bromide poisoning depends not only on the amount of the drug but also the age, general health, and condition of the heart, blood vessels, and kidneys; old people with arteriosclerosis are particularly susceptible to bromide poisoning. Sodium chloride is used as an antidote; it replaces bromide in the body.

Barbiturates.—When barbiturates are being given to a patient, the following points are important to keep in mind: Barbiturates depress the respiratory center; after an intravenous injection watch respiration closely. Counteracting drugs are picrotoxin and camphor.

The barbiturates are mildly habit-forming. Elimination is slow, and the drug is excreted almost wholly through the kidney. Watch bladder (drug excreted in urine) and bowel (tendency to constipation) elimination. Following intramuscular or subcutaneous injection, watch for local irritation. It is important to have information regarding solubility of the drug being used, as some preparations are insoluble in water. Because of an occasional idiosyncrasy to excitement produced by these drugs, barbiturates are frequently combined with another drug such as sodium bromide, phenacetin, or paraldehyde.

People who are mentally ill can tolerate larger doses of these drugs than those who are not; the therapeutic dose is often what

ordinarily is considered a toxic dose. Barbiturate poisoning occurs in the following order: barbital (veronal), most frequently; phenobarbital (luminal); sodium amytal, rarely. If use is continued, watch for symptoms of pulmonary edema, pneumonia, and excitement.

The outstanding unfavorable symptoms resulting from the use of barbiturates are vertigo, pyrexia, and rash. Additional unfavorable symptoms are headache; nausea; vomiting; decreased, shallow respiration; rapid pulse; cyanosis; hippus (tremor of iris, pupil rapidly changes size); any change in mental reactions (apathy, increased psychomotor activity, pronounced agitation, impulsive behavior). Watch for idiosyncasy to excitement.

Following are the outstanding characteristics of *barbital (veronal)*:

Dosage	The dose is usually 5 to 15 grains (0.3 to 1 gm.).
Administration	The powdered form is best; if tablets are used, crush these before giving to the patient; give in hot liquid, preferably milk.
Effect	This drug takes effect within an hour; the patient usually sleeps 4 to 8 hours, the action being slightly shorter than with phenobarbital.
Overdose	Watch especially for sign of diplopia; see also unfavorable symptoms for barbiturates in general.

Points to be remembered in administering *sodium barbital* are the following:

Dosage	The usual dose is 3 to 8 grains (0.2 to 0.5 gm.); this can be repeated at intervals of 6 hours.
Administration	There are preparations for oral, rectal, subcutaneous, intramuscular, and intravenous administration.
Effect	This drug acts quickly, but the sleep is of shorter duration than with barbital or phenobarbital.
Overdose	If this drug is used on old or weakened people, watch closely for unfavorable symptoms; see also unfavorable symptoms for barbiturates in general.

The following points concerning *phenobarbital (luminal)* are significant:

Dosage	The usual dose is 1 to 3 grains (0.06 to 0.2 gm.).
Administration	The drug is administered best in powdered form by capsule.
Effect	This drug is slow in taking effect, but the action is longer than that of the other barbiturates.

Overdose..... Appreciate that the elimination of this drug is much slower than of barbital (veronal); for unfavorable symptoms see general discussion of barbiturates.

Chloral Hydrate.—This is a useful and cheap drug. Some years ago it was used indiscriminately, which led to an appreciation and fear of its dangers. The drug fell into disuse but is being revived.

Dosage..... The average dose by mouth is $7\frac{1}{2}$ to 15 grains (0.5 to 1 gm.); larger doses are given if administered by rectum.

Administration..... Chloral hydrate is irritating to the lining of the stomach and if not well diluted causes gastric irritation. If administered orally give in well-diluted solutions (water, warm milk); if administered by rectum give in water or olive oil. Chloral hydrate cannot be used hypodermically and should not be given with alcohol, as chloral alcoholate is formed.

Effect..... This drug takes effect in 30 to 60 minutes; the usual length of sleep is 4 to 8 hours.

Elimination..... Elimination is chiefly through the kidneys.

Overdose..... Unfavorable symptoms include headache; dizziness; nausea; flushing of the face; cold extremities; gastrointestinal disturbances; cyanosis; relaxed muscles; contracted pupils; skin rash; inflammation of eyes; mental reactions—insomnia; delirium; tremor; coma; and in old people, sleep walking with amnesia for behavior. Prolonged use produces mental depression and impairment of mental power. An overdose may cause cardiac and respiratory depression; the poisonous action on the heart, when it occurs, is due to the chlorine content; death is due to respiratory paralysis.

Paraldehyde.

Dosage..... The dosage depends upon the method of administration; average doses are as follows: orally, 2 to 4 dr. (8 to 16 cc.); rectally, 4 dr. (16 cc.); intramuscularly, $2\frac{1}{2}$ dr. (10 cc.); intravenously, 2 cc.

Administration..... In giving paraldehyde by mouth be sure the drug is fresh and well diluted (not too much to drink); chill or serve in ice water, with cracked ice, with cold milk, or with fruit juice if it does not make the patient dislike the fruit juice; appreciate that the drug has an unpleasant odor and hot burning taste. By rectum use olive oil as a vehicle. For intramuscular administration give deep into the gluteal muscle. The drug is antiseptic and does not require sterilization for intravenous use.

- Effect..... This drug takes effect quickly; by mouth, within 30 minutes. Sometimes it produces a drug habit.
Elimination..... Elimination is chiefly through the lungs, some through the kidneys.
Unfavorable symptoms. Watch for bronchial irritation; prolonged use may cause chronic intoxication, the symptoms of which are similar to chronic alcoholism.

Sleep Disturbances.—*Asomnia* is insufficient or reduced sleep. Such a condition is found in depressed states, in the neuroses (indecision, doubt, fear), in manic states where the patient is unable to withdraw his interests, and sometimes in patients with head trauma causing a hyperexcitability.

Dyssomnia is unrefreshing sleep. This condition is frequent with patients who are mentally ill, although usually the complaint is a lack of sleep.

Hypersomnia is excessive sleep. This condition is found in patients with brain tumors and vascular disorders affecting the hypothalamus, in metabolic disturbances (particularly carbohydrate combustion), and in patients with a reduced interest in the environment.

Insomnia is a chronic inability to sleep. Here the sleeplessness is the primary complaint, and the pathological basis is not easily observed. This condition is common among those who are mentally ill and is an outstanding early symptom.

Narcolepsy is a sudden attack of sleep. The person suffering with narcolepsy is suddenly overcome with sleepiness; the attacks occur one to three or four times a day (three or four is unusual); the sleep may last for a few seconds to several hours. This disorder is occasionally idiopathic (primary) but frequently is a sequel to encephalitis.

Somnolence is a continuous tendency to drowsiness. This condition is found in patients with cerebral processes such as meningitis, hydrocephalus, brain tumor, and with patients who have a reduced interest in the environment, myxedema, or senile arteriosclerosis.

SUICIDE

Occurrence.—If there is opportunity, suicide is common among those who are mentally ill; in fact, all people who are mentally ill are potential suicides. Suicides do not usually take place on a

ward. Hallways and particularly rooms adjoining the ward such as bathrooms, toilets, lavatories, closets, and service rooms are favorite places.

Reasons for Suicide.—Outstanding reasons for suicide are the desire to escape unbearable emotion or to escape delusions of persecution; or it may be the result of an unpremeditated, impulsive act.

Prevention.—The prevention of suicide is one of the psychiatric nurse's greatest responsibilities. There are only two outstanding methods, namely, to eliminate and reduce opportunity and to provide constant supervision.

Legal Responsibility.—Public institutions are required to show proof of adequate supervision.

Ways and Means of Committing Suicide.—The following ways and means are all used by patients in an attempt to commit suicide:

Burning.—Patients set fire to their clothes and bedclothes.

Cutting, Stabbing.—Patients cut wrist or neck by the use of sharp instruments, such as a razor, knife, scissors, ice pick, or sharp instruments taken from places such as the kitchen or occupational-therapy department; or with glass from a watch crystal, eyeglasses, glassware from the dining room and meal trays, windowpanes, or glass picked up in the street or in the yard.

Drowning.—The ward bathtub or a nearby river or lake offers possibilities.

Falling.—Sometimes a patient will fall down a shaft—laundry, elevator, food elevator; or while out walking throw himself under a bus, a street car, or an automobile.

Hanging.—The bed sheet is the most common means for hanging. The patient attaches this to a window grill, a chandelier, or a ventilator; stands on a chair; and then pushes the chair away. If you find a patient hanging, lift the body in order to stop suspension (if this is physically impossible, have anyone around help you); release the means of suspension and loosen whatever is around the neck; begin artificial respiration if breathing has stopped; ask whoever is at hand to get the nurse in charge of the ward (also to tell her there is an emergency) and to call a physician.

Jumping from High Places.—Jumping from window sills, the lavatory in the bathroom, tops of furniture, or a balcony, and throwing oneself headlong down the stairs or over banisters are all tried at one time or another.

Knocking the Head.—Patients knock their heads against a wall or the floor and charge into radiators.

Poisoning.—If there is any poison or harmful liquid available, some patient is sure to swallow it. An escape always means the possibility of purchasing poison (if the patient has money) at a local drugstore.

Starvation.—Suicidal intent is a fairly common reason why a patient will not eat.

Strangulation.—Belts, pajama and bathrobe cords, neckties, towels, and bedclothing are all used for this purpose. Immediate nursing care is the same as for hanging.

Suffocation.—Patients try to smother themselves under the bedclothes; now and then a patient shuts himself in a closet, usually one that is not opened often, such as a closet containing pipes for heating or plumbing.

Special Nursing Points. *Newly Admitted Patients.*

1. Search for contraband material.
2. Watch closely; history and clinical data may be insufficient.

All Patients.

1. Appreciate that each patient is a potential suicide.
2. Do not allow patients in rooms with the doors closed.
3. Do not allow patients to linger in bathrooms and toilet sections.
4. Do not allow patients to shave themselves unless there is a physician's written order. When a patient is permitted to shave himself, use a safety razor only, supervise constantly, and do not allow the patient to handle the blade.

"Suicidal" Patients.

1. Know which patients are particularly suicidal; they are so designated by a physician.
2. Never leave patients alone.
3. Watch tendency of patients to get behind doors and into bathrooms unaccompanied.
4. Know at all times exactly where the patient is and exactly what he is doing.
5. Watch the patient particularly if there is a sudden appearance of restlessness and agitation, such as pacing the floor, when

the patient had not done this before; if he is eager to join some outside activity (especially a patient with agitation who has not shown such an interest previously); if there is a sudden improvement in a badly depressed or delusional patient; if the patient has a history of previous suicidal attempt. Watch this type of patient also during convalescence from depression (at this time the patient thinks more clearly and there is activity which makes the suicide act easier to carry out); at times of change (of nurses, of ward personnel, or change from one ward to another); during the early morning if the patient is awake; and at night (when the patient seems asleep, listen to his breathing, make visits at irregular periods, keep some kind of record (see sleep chart) to account for the patient's presence and condition every half hour even if the hospital does not require one).

6. If possible have these patients sleep in an open ward.
7. After the patient has had visitors, watch closely and search for prohibited articles.
8. Open incoming packages in the presence of the patient, or have the patient open the package in the presence of a hospital worker.
9. When patients are out of doors, keep the group together; do not allow some patients to lag behind or go ahead; when accompanying a patient on the street, walk on the outside so that he cannot fall in front of a passing automobile.

Dangerous Articles, Poisons.—These include sharps, medicines, cleaning fluid, etc.

1. Use special care regarding hospital rules (see discussion of accidents, page 168).
2. Make sure that patients do not bring dangerous articles to the ward from other departments, such as the occupational-therapy department, dietetic department, etc.
3. Realize that hospital workers such as a plumber, carpenter, or painter do not always understand what is expected of them regarding the care of their tools, and help carry this responsibility.
4. Appreciate that, while money in itself is not a dangerous article, patients collect money in order to escape and buy suicidal goods.

Rooms Adjoining the Ward.

1. Keep all such rooms locked when not in use.
2. Check bathrooms regularly.

Definite Responsibilities of Head Nurse.—The heaviest nursing responsibility regarding suicide falls on the head nurse.

General.

1. Eliminate and reduce opportunity.
2. Provide constant supervision.
3. Help the ward personnel to have a better understanding of the problem and how to deal with it.

Particular.

1. Pay attention to suicidal list: Keep in the nursing station out of sight. Do not remove any name from the list without a physician's order, and have the ward physician check the list once a week.
2. Do not confine responsibility regarding suicide only to patients on a suicidal list.
3. Daily search clothing, bed, and room of patients on the suicidal list; if possible, do this without the patient's knowledge.
4. Make certain that patients do not bring dangerous articles to the ward from other departments.
5. Make special assignments regarding suicidal patients—have a certain nurse responsible for a certain patient for a definite period of time.
6. Have an emergency tray at hand containing stomach pump, emetics, heart and respiratory stimulants, and antidotes (consult ward physician).
7. Have a standard first-aid book in the nursing station.

Attempt at Suicide.—In meeting such a situation the shock is so great that the immediate reaction is not to touch the person, especially if he looks dead, or to go for help. The outstanding aim is to save a life —attend to the patient first; have someone else get the nurse in charge of the ward and the physician.

Record.—For a record of suicide or attempted suicide hospitals use the accident report (see page 173).

REFERENCES

BOOKS¹

- American Red Cross First Aid Textbook, corrected reprint, The Blakiston Company, Philadelphia, 1940.
- DAVISON, FORREST R.: "Synopsis of Materia Medica, Toxicology and Pharmacology," The C. V. Mosby Company, St. Louis, 1944.
- FADDIS, MARGENE O. and JOSEPH M. HARMAN: "Textbook of Pharmacology for Nurses," 2nd ed., J. B. Lippincott Company, Philadelphia, 1943.
- FITZSIMMONS, LAURA W.: "A Manual for Training Attendants in Mental Hospitals," The American Psychiatric Association, New York, 1945.
- HUNT, J. McV.: "Personality and the Behavior Disorders," The Ronald Press Company, New York, 1944.
- JACOBSON, E.: "You Must Relax," McGraw-Hill Book Company, Inc., New York, 1934.
- LENNOX, W. G.: "Science and Seizures," Harper & Brothers, New York, 1941.
- LENNOX, W. G.: "Seizure States." "Personality and the Behavior Disorders," J. McV. Hunt, Editor, The Ronald Press Company, New York, 1944.
- MUSE, MAUDE B.: "Pharmacology and Therapeutics," 4th ed. rev., W. B. Saunders Company, Philadelphia, 1944.
- PUTNAM, TRACY J.: "Convulsive Seizures: How to Deal with Them," J. B. Lippincott Company, Philadelphia, 1943.
- SELLING, LOWELL S. and MARY A. S. FERRARO: "The Psychology of Diet and Nutrition," W. W. Norton & Company, Inc., New York, 1945.
- SOLOMON, CHARLES and HAZEL HOUSTON: "Pharmacology, Materia Medica and Therapeutics," 5th ed., J. B. Lippincott Company, Philadelphia, 1943.
- STERN, EDITH M. and SAMUEL HAMILTON: "Mental Illness: A Guide for The Family," Commonwealth Fund, New York, 1942.
- TERHUNE, WM. B.: "Psychological First Aid," The Connecticut Society for Mental Hygiene. (23 pages.)
- WOODERS, MARIE A. and DOLAND A. CURTIS: "Emergency Care," F. A. Davis Company, Philadelphia, 1942.

ARTICLES

- BONNER, C. A. and LOIS E. TAYLOR. "A Study of Accidents in a Mental Hospital," *The Journal of Psychiatry*, September 1939, pp. 283-295.
- DAVISON, CHARLES. "Psychological and Psychodynamic Aspects of Disturbances in the Sleep Mechanisms," *The Psychoanalytic Quarterly*, October 1945, pp. 478-497.
- DILLON, F. "Suicide," *The British Medical Journal*, December 15, 1934, pp. 1098-1100.
- FAIRBANK, RUTH. "Suicide: Possibilities of Prevention by Early Recognition of Some Danger Signals," *The Journal of the American Medical Association*, May 14, 1932, pp. 1711-1714.

¹ See list of textbooks for nurses on page 163.

- HILL, J. M. "Incontinence in Acutely Psychotic Patients," *The Psychiatric Quarterly*, April 1939, pp. 294-302.
- JAMEISON, G. R., and J. H. WALL. "Some Psychiatric Aspects of Suicide," *The Psychiatric Quarterly*, April 1933, pp. 211-229.
- JAMEISON, G. R. "Suicide and Mental Disease—Clinical Analysis of 1 Cases," *Archives of Neurology and Psychiatry*, July 1936, pp. 1-12.
- LENDRUM, F. C. "A Thousand Cases of Attempted Suicide," *The American Journal of Psychiatry*, November 1933, pp. 479-500.
- LIPSCHUTZ, LOUIS S. "Some Administrative Aspects of Suicide in the Mental Hospital," *The American Journal of Psychiatry*, September 1942, pp. 181-187.
- MEYER, LOUISE ALLEN. "Restraint in the Care of Psychiatric Patients," *The American Journal of Nursing*, June 1945, pp. 445-449.
- POLLACK, BENJAMIN. "A Study of the Problem of Suicide," *The Psychiatric Quarterly*, April 1938, pp. 306-330.
- RITTMAN, F. "On Predictability of Suicide," *The Journal of Mental Science*, October 1942, pp. 580-582.
- SIEWERS, A. B. and E. DAVIDOFF. "Attempted Suicide; Survey of 150 Patients Admitted to 2 General Hospitals," *The Journal of Nervous and Mental Disease*, April 1942, pp. 427-441.
- TUCKER, EVELYN. "A Sleep Graph," *The American Journal of Nursing*, November 1933, pp. 1048-1050.
- WILSON, TABITHA. "Feeding Guidance for Mental Patients," *The American Journal of Nursing*, February 1936, pp. 137-146.
- WITTISON, CECIL. "Treatment of Problem of Nutrition in Mental Cases," *The Psychiatric Quarterly*, July 1934, pp. 499-510.
- YALL, LOUISE. "Nurses and Suicide Prevention," *The American Journal of Nursing*, September 1934, pp. 882-886.

CHAPTER VII

NURSING CARE: REHABILITATION

Meaning.—Rehabilitation refers to the complete restoration of an incapacitated individual. The word "complete" refers to mental health, physical health, satisfactory social relationships, and independent economic status.

Group of Workers.—Rehabilitation requires a program of activities carried out by a group of workers. The key participants with their outstanding functions are the following:

Physician.—The psychiatrist is the outstanding physician. He deals directly with the patient's main problem or chief complaint, plans and guides all activities, and directs special programs of research. Physicians in other special fields—internist, surgeon, neurologist—are also necessary or at least should be available for consultation.

Psychologist.—The psychologist applies a battery of tests and evaluates potentials—intelligence, aptitude, performance, skill, temperament, and personality type. The results guide the psychiatrist in his objectives and program of treatment. The patient's state of health cannot be greater than his potentials.

Dentist.—One or more resident dentists are usually a part of the hospital personnel.

Nurse.—The nurse assists the physician by carrying out his orders regarding specific treatments; helps contributory therapists—occupational therapist, recreational therapist, etc.; and has an active function of her own, namely, to create a therapeutic atmosphere; to modify moods and change attitudes, particularly in relation to environmental situations; and to initiate and establish healthy reactions.

Attendants.—Attendants assist in the care of the patient, particularly in relation to routine activities. The spirit and attitude of the attendant group reflect the spirit and attitude of the nurses.

Laboratory Technician.—This worker is concerned chiefly with the physical health of the patient through the examination of

blood, urine, etc., and the sanitary conditions of the institution as shown in the bacterial count of the water and milk supply, etc.

X-ray Technician.—This member of the hospital staff is concerned with diagnostic measures, particularly the presence of tuberculosis and fractures.

Dietitian.—The dietitian is interested primarily in the physical health of the patient. This field has opportunities for research, as there is a possibility of a definite relationship between food and mental mechanisms.

Pharmacist.—This worker makes solutions and dispenses drugs.

Personnel for Special Activities.—This group consists of the occupational therapist, instructor in physical education, recreational therapist, physiotherapist, director of music, chaplain, and librarian. It also includes speakers and teachers for formal education.

Social Worker.—The social service department holds a very important and active place in the total therapeutic program.

Teamwork.—The entire personnel work together and often at the same time in helping the patient make himself a socially efficient individual. The psychiatrist directs all activities and integrates these activities toward a planned program relating to the special needs of the particular patient. All workers require study oriented to this field.

It may seem superfluous to state that it is very important for the nursing personnel to fall in line wholeheartedly with the general program as established by the physician. However, the psychiatric nurse has considerable margin for action (this is largely because of her constant contact with the patient and the immediate pressure to do and say something and because specific orders for psychiatric aspects of care are not many in number), and the very nurse who has sufficient energy, enthusiasm, interest, and knowledge to be of value will probably have ideas of her own and be tempted at times to see how they work.

Therapeutic Goal.—The therapeutic goal is to get the patient well and have him leave the hospital as a socially efficient individual. Usually this requires that the patient gain insight into the mechanisms of his illness and that new habits of reaction be established.

Regarding the patient's chances for successful living, these are not better than the potential equipment—heredity and early

life experiences are particularly important—and also depend on the length of time he has been ill. Therapy is divided into central and contributory.

Central therapy is a physician-patient affair. It is largely the physician's program of education, orienting the patient to his illness—the nature, causes, how the symptoms developed, why they persist, recognition of the problem.

Contributory therapy relates to all the other activities being carried out at the same time in order to meet the different personal needs—physical, intellectual, emotional, social, spiritual. Some of these are supportive measures only; but all activities are planned to establish security, to develop sound self-reliance, and to promote integration.

CONTRIBUTORY THERAPEUTIC ACTIVITIES

Kinds.—The contributory therapeutic activities include the physician's definite orders for specific treatment—drugs, shock therapy, hydrotherapy, etc.; tests—various psychometric tests, tests on blood, urine, etc.; dental work; dietary measures; hygienic measures; and habit training. Other activities are occupational therapy, physical education, recreational therapy, and physiotherapy, as well as religious activities, bibliotherapy, resocialization, formal education, and social-service activities.

General Need.—The total therapeutic program is designed to meet the needs of the whole person. Nursing care is only a part. On the medical and surgical ward you realize that often you can supply most of what the patient needs to get well; but on the psychiatric ward you soon recognize that the patient requires much more than you as an individual can give. Integral activities are of a wide range.

All activities are carried out according to medical order or advice, and special fields such as occupational therapy or physiotherapy should be administered under the supervision of workers who not only have had special preparation but who also have an understanding of the patient as well as academic knowledge of the subject matter. All departments are responsible directly to the medical department. In special fields the nursing personnel works in an adjuvant position to the person in charge of the particular field.

From the very day the patient enters the hospital there is an attempt to utilize available capacities toward a better equilibrium in living. The immediate measure is activity, which helps reduce any particular feeling state. For some time this is confined largely to simple ward activities, but as the treatment of the illness progresses and energy that had been going into destructive behavior (morbid thoughts and feeling states and ineffectual conduct) is released, constructive purposeful activity is pushed. You have a vital role in these contributory therapeutic activities, a role that at first is not easily understood.

When a supervisor comes unexpectedly upon a young student nurse playing cards with a patient, the student invariably shows signs of embarrassment as though caught in an unprofessional act. And when a young nurse is asked what she did at "psycho" during the day, one sometimes overhears something like this: "I had a fine time. In the morning I helped two patients plant some flowers; in the afternoon we went for a long walk in the park, rested a little while, then read a few chapters from Sir Richard Livingstone's book, 'On Education,' and then came back to supper. I certainly did not work hard." This sounds very pleasant, but something is missing.

To begin with, notice that the emphasis is in the wrong place. These are not patients just playing cards, planting a garden, or taking a walk. They are people trying to get a hold on living. How do these activities contribute to the goal? What are these people really like? How do they think? What are their feeling states? What do they talk about? Does their behavior correspond to their inner thoughts and feelings? What happens to them while they do these things? How much animation do they show? Is there any difference in their appearance when they are active and when they are inactive? What kind of activity stimulates the greatest interest? Are there signs of courage, of confidence? Is there any difference in the behavior today over yesterday, last week, last month, or over admission?

It takes a while to learn what has to take place between the time the patient is admitted to the hospital and the time when he is able to play a game of cards, plant flowers, take a walk, or be interested in a book on education. When a patient is willing and eager for these things, he is probably about ready to go home.

During the height of the mental illness the patient cannot work,

cannot play, cannot rest; he has lost faith in himself and in others; he has little or no love in his heart, or, if he has, this too is out of line; his energy goes into destructive activity, particularly the destruction of himself—not wholly a matter of suicide but the destruction of spirit which gives vitality, life. *And*, he cannot stir himself out of this wretched state without help.

Psychiatric treatment, if successful, releases this misdirected energy; but the release of energy does not mean that it will be used at once or wisely. At this point the patient has to be taught how to work, how to play, how to rest, and furthermore how to acquire a balance in these activities.

Nursing Responsibilities.—Regarding these special activities, you should carry on under direction and supervision as given by the physician or special therapist. You should appreciate their values, know the general and specific objectives, and realize the motives back of the plan. You are expected to perceive your own positive function and know your limitations. Following are a few detailed responsibilities.

1. Add to your store of knowledge on the activities being used.
2. Have the patient ready and eager for scheduled activities.
3. Know your responsibility concerning the use of materials and equipment.
4. See that the patient basks in an atmosphere of understanding and emotional safety.
5. Try to comprehend what goes on inside of the patient as reflected in the mood and attitude.
6. Watch eagerly for the evidence of interest (patient pays attention), special aptitudes, confidence, and wholesome satisfactions.
7. Be alert to signs of fatigue—lack of interest, irritability, carelessness, hilarity, and confusion.
8. Motivate the patient toward advanced activities.

Physician's Orders.—Physician's orders are definite and relate mostly to specific treatments. They require knowledge of nursing skills and the carrying out of established procedures.

Tests.—The psychologist asks to have patients come to the psychological laboratory; the nursing personnel meets the psychologist's request by accompanying the patient to the laboratory. If the psychologist does not prepare the patient for the procedure

before leaving the ward, an explanation should be given to the patient as to where he is going and why. It is wise to learn from the psychologist just what he wants said to the patient.

Laboratory tests on blood or urine are taken care of through ward or hospital routines.

Dental Work.—The dentist, like the psychologist, carries out his own program; the nursing personnel takes the patient to and from the dental offices. When the dental department has sufficient personnel, they often provide the escort. These details are taken care of by hospital administration or supervision.

Dietary.—The preparation of food falls on the dietary department. The nursing personnel work closely with the dietitian regarding special diets ordered by the physician and information on patient reactions and needs, also on matters of waste. Study the patient in relation to food interests, habits, and attitudes, and report these to both the physician and the dietitian.

Hygienic Measures.—Hygienic measures are a very important part of the nursing care of all patients, particularly those on the admission and disturbed wards. When a patient is very active, the tangible objective in nursing care is chiefly the personal hygiene of the patient. Matters of hygiene are well known to all nurses. The practical problem here relates to the antagonism in the patient.

That the patient is bathed and his hands clean may relate only to nursing skill; the psychiatric aspect is the reduction of indifference or antagonism and the development within the patient of a desire to meet these personal needs himself.

Habit Training.—Regarding habit training, the initial step is attention to personal habits—elimination, eating, and appearance. Physical exercise, recreation, and social relations are all a part of habit training.

Value.—In habit training the use of energy is organized and a rhythm in living which furnishes momentum comparable to regimental marching is established. Energy is mobilized toward a specific end. Also, a strong motivating force in behavior is provided, unnecessary mental activity is reduced, and energy is freed for progress or advancement.

Importance.—Habit training is especially important for those who are mentally ill, because there is something definitely wrong with their mobilization and utilization of energy.

Many patients find it difficult to do anything—even fundamental activities such as eating, urinating, and sleeping. Some patients, if they do anything, want to do it in their own way and at their own time—this disturbs any group life and is often the reason why the patient is sent to the hospital. Still others have a stickiness about their activities—if they sit or stand, they sit or stand indefinitely; if they talk, they keep on talking; if they take hold of something, they cling to it. Many patients never relax, never play.

Habit training in itself may not remedy the defect or change in the mobilization or utilization of energy, but, in line with psychiatric treatment, it has a definite place in rehabilitation.

Responsibility.—The responsibility for habit training falls largely on the nursing personnel.

Principles.

1. Simplify the situation.
2. Study the patient's mood and attitude.
3. Appeal to the senses.
4. Stimulate interest—not particularly in relation to habit training; any interest stimulates movement, life.
5. Carry out the desired activity in the right way and at the exact time.

Method.—The outstanding method of habit training is the use of ward routines and activities. Detailed routines are organized and established on a schedule basis. The hospital sets a certain time for the patient to get up, to eat his meals, to go to bed, etc.; the ward establishes routines regarding bathing, elimination, etc.; and special activities, such as treatment programs, occupational therapy, etc., are carried out with planned regularity.

Besides daily routines, the ward provides a regular time for the patient to attend to personal duties such as mending clothes—runs in hose, loose hooks or buttons, patching, and reinforcing weak spots; and for “cleaning house”—discarding waste paper and trash, putting bureau drawers and wardrobes in order. Some of these duties are not carried out by male patients, but they need to clean house regularly—brushing out tobacco, etc.

Habit training includes training in attitudes toward daily activities and other patients. No one lives alone, and people have to be able to depend on each other. For example, a person does

not enjoy living with another who is irresponsible as to time (his time as well as another's) or undependable in what he says he will do. Establishing habits that aid in adjustment with others is brought about more through the spirit and attitude of the nursing personnel than through actual ward routines.

Regarding habit training, two outstanding precautions to be observed are these: You should appreciate patient limitations and recognize that ward routines sometimes have a deadening effect.

Because of the patient's limitations the organization of detailed routines is often not enough. You may have to be the dynamo, the spark plug, and anything else that is needed to get the energy in motion. You may need to address each patient individually and tell him just what to do next—"wash your face," "brush your teeth," "comb your hair"—and you may have to give directions only one at a time and repeat them every time the particular activity is desired. You may even have to initiate the actual activity; for example, after you tell the patient to comb his hair, it may be necessary to direct his hands. Do not grow careless, going ahead and doing the things yourself just because it is easier. Your ultimate objective is to get the patient to do these things for himself.

When habits having to do with daily activities are mastered, appreciate that routines and detailed schedules may become deadening. Do not shut out chances for spontaneity. Again, the fact that the patient lives on the ward where activities meet his particular needs is of some help.

Occupational Therapy. *Use.*—Occupational therapy is any mental or physical activity used as a form of treatment for the sick and injured. It is not confined to people with mental disorders, although this is the field which is of particular interest here.

Meaning.—Occupational therapy is purposeful occupation prescribed by a physician to meet special needs of a particular patient. It refers to a concrete task with a specific goal. Occupation itself is not the end. Effort (application to a task) and achievement (sense of triumph) are objectives. The quality of work is measured in relation to the patient's capacity at the time, and expected achievement must always be set within the range of working potentials.

Value.—The activities prescribed for the patient compel his attention and make it possible for him to spend his excess energy. They provide an outlet for restrained energy and help him to

utilize it constructively. The patient is forced to organize his thoughts and ideas, and morbid thoughts and feelings are replaced with healthy ones. Emotional tension is released, and unsocial tendencies, particularly aggressive behavior, are sublimated. Normal interests are established and new interests presented. The patient's creative talents are developed, and at the same time his self-confidence and self-esteem are reestablished. His accomplishment of specified tasks helps to build morale. The group activities create a social atmosphere, promote a spirit of cooperation, and develop group responsibility.

When there is an occupational-therapy program, there is a noticeable reduction in active aggressive behavior with its consequent sedation, seclusion, and mechanical restraint.

Objectives.—The general objective of occupational therapy is to contribute to and hasten recovery. Specifically, it is intended to institute healthy mental and physical activities; to build a rich, full, satisfying inner life (stimulate initiative, imagination, and creative effort; arouse interest, courage, and confidence; develop self-expression; introduce subjects of interest and use—pleasure in ideas and satisfaction in practical methods); to promote precision; to fix normal work habits; and to establish a capacity for social usefulness.

Program.—The program for occupational therapy is progressive. Activities are maintained on the highest level of the patient's capacity—a capacity will increase only if pushed to the limit. In general, the program should be diverting, interesting to the particular patient, and useful.

Prescription.—All occupational therapy is instituted by individual prescription. The prescription is ordered by the physician to meet a particular need.

When the particular need is to quiet or to calm, a sedative occupation is ordered. Such an activity is repetitious and has uniform movements that, because of their monotony, have a soothing and quieting effect. An example is simple weaving. This type of activity is usually prescribed for an overactive patient.

When the particular need is to arouse, a stimulating occupation is ordered. Such an activity is lacking in repetition and monotony and provides variation in the process, for example, type setting. This type of activity is usually prescribed for the slow, retarded patient.

Other angles considered in prescribing occupational therapy are: the activity—complexity, speed; the mental process required—concentration, initiative; the patient's mental and physical coordination; and the physical condition.

A physician's prescription for occupational therapy may read something like this: "Sedative, sedentary occupation." Besides this specific order there are usually spaces on the order sheet for additional information for the therapist, such as general results of psychometric testing, the patient's occupation in life, the tentative diagnosis, any history of seizures, physical condition as it relates to occupational therapy, interests expressed by the patient regarding forms of work, and precautions to be observed.

The occupational therapist translates the physician's prescription into an actual activity. In selecting an activity the occupational therapist considers the objective of treatment, the type of patient, and the available equipment and facilities.

The objective of treatment is always given in the physician's prescription and is discussed further at conferences.

Regarding the type of patient, some details to be considered are the sex of the patient, his aptitude, capacity for learning, cultural background, interest, intelligence, and mood and attitude. His physical condition and particular handicaps must also be considered, as well as symptoms of illness (suicidal tendency, destructiveness, depression and depth of depression, and mental deterioration).

Points for consideration in regard to equipment and facilities are the place—workshop, industry; actual equipment available; money allowed; time, knowledge, and interest of personnel concerned; and special hazards (dangerous articles are not given to patients with suicidal tendency).

Activities.—The possibilities in activities are legion. For convenience they are broken up into the following divisions: ward, shop, and industry.

The occupational-therapy department may have classes on the ward as per a schedule; also, some of the ward activities are useful occupations. These may be, particularly on the disturbed wards, cutting, tearing, and winding rags; sorting colors; raveling burlap, stockings, and underwear; winding yarn into balls; sandpapering; and making scrapbooks.

Therapeutic ward activities are the things the patient does by himself. The therapy is indirect, and the process is sublimative. Activities are chiefly housekeeping duties such as making beds; sweeping; general cleaning; dusting; polishing floors, furniture, and silverware; washing beds, windows (inside), and walls; care of clothes; care and arrangement of flowers and plants; care of birds; attention to bathrooms, utility room, and linen room (folding linen, arranging on shelves).

Occupational-therapy shop activities consist largely in arts and crafts. Art work includes carving (soap, wood), designing, drawing, dyeing, modelling, painting, sculpturing, and stenciling. Basketry, block printing, cutting linoleum blocks, needlework and allied activities (beading, crocheting, embroidering, hemstitching, knitting, quilting, tatting), and weaving of all types (cardboard, hoop, pillow, loom—hand and foot) are some of the crafts taught. Also, the patients work with various media—clay, concrete, leather (cutting, lacing, tooling, appliqué, embossing), metal (brass, copper, lead, silver, tin), paper, papier-mâché, plastics, plaster of paris, raffia, reed, wax, and wood.

In industrial occupational therapy the emphasis is on constructive, useful activity. Work has curative value. The work program of the hospital is organized to meet patient needs. Outstanding objectives in industrial occupational therapy are to establish work habits, to provide incentive in usefulness, to offer a form of vocational training, and to increase self-respect (the patient appreciates that he is an important member of the hospital unit).

In assigning a patient to industrial occupation the following requirements must be met: The assignment must be in accordance with medical advice. The patient must be placed in the hospital industry which will be most beneficial to him. There must be qualified supervision—the employee must also be a teacher and supervisor of patients. The task must be organized to meet the patient's need—the work is selected for the patient, not the patient for the work. The patient must have an appreciation of the specific goals and know how to reach them. The principal idea back of industrial occupation is therapy, and the criterion of success is the therapeutic effect upon the patient.

The large hospital for the mentally ill offers much in the way of

potential industrial occupational therapy. Following is a partial list of places and activities:

- Bakery
- Barn—horse, cow
- Bookbinding
- Brush making
- Carpentry work
- Cabinetmaking
- Furniture—construction, upholstery, repair
- Chair seating—cane, flat reed, splint, rush
- Toys
- Jigsaw puzzles
- Construction work—cement sidewalks, roads, bridges, walls, fences
- Dairy
- Dining rooms
- Electrical work—lighting, electric equipment
- Farm
- Garage
- Garden—vegetables
- Greenhouse and grounds—flowers, trees, landscaping
- Kitchen
- Laundry
- Mattress making
- Paint shop—house painting, sign painting
- Plastering
- Plumbing
- Power plant
- Print shop—hospital charts, pamphlets, manuals, newspaper
- Sewing room—making new garments, mending old garments, making clothes
- Shoemaking and repairs
- Tailor shop

Records.—The patient's record on occupational therapy usually comes to the ward and is a part of the ward chart. This record shows the occupation, the number of hours or days, the interest shown, the success in the particular activity, any peculiarities in behavior or conversation, sociability, teachableness, and the improvement under direction.

Physical Education. Meaning.—Physical education is prescribed exercise and is a form of physical medicine.

Value.—Outstanding values in physical education are the following: Metabolism is increased—respiration deepened, heart action quickened, glands of the skin stimulated, and elimination of waste products aided; emotional tension is released; energy is used constructively; and the mind is stirred to activity. As to

the physical aspects, strength, endurance, agility, skill, and speed are developed.

Effect.—When there is a definite program of physical education, patients eat better, sleep better, are less irritable; in general, they are more alive during the day and calmer at night.

Requirements.—Outstanding requirements for physical education for patients are medical advice and qualified supervision.

Activities.—The principal forms of activity are posture, exercise, calisthenics, and gymnasium and athletic activities (vigorous sports).

Responsibility concerning the patient's posture is usually placed on the nursing personnel. If you do not have adequate information regarding correct posture for different activities—sitting, standing—and knowledge of the principles of body mechanics, obtain specific instruction and supervision from the physical therapist. It is thought by many that the importance of posture is not stressed sufficiently.

There should be a definite plan for exercise, in keeping with a total hygienic program and the patient's state of health. If there is a physical education director, he (or she) will manage any explicit, progressive feature. When there is no special instructor, nursing obligations and responsibilities are increased. Obtain orders and suggestions from the ward physician.

Simple exercise is initiated through the following means: recreation, ward activities, walking, marching, and rhythmic tapping and clapping. The established program of recreation affords exercise, also ward activities such as sweeping and dusting; however, this is not enough. The patient should go on walks, preferably out of doors.

It is well to conduct marching around the ward, especially when it is raining or when patients are not allowed out of doors. At such times, open the windows. Be sure the patients are sufficiently warm—put on coats, hats, and gloves if necessary. Patients like this idea of dressing up, and it provides additional purposeful activity. Music is of value in marching and for rhythmic tapping and clapping and is particularly helpful in carrying out such activities with disturbed patients.

Group calisthenics or drill is given on the ward, in outdoor inclosures, or in the gymnasium. The nursing personnel is sometimes responsible for setting-up exercises and simple gymnastics.

Some of the gymnasium and athletic activities are the use of mechanical appliances, motor-driven apparatus, dumbbells, and Indian clubs; basketball, volleyball, handball, medicine ball, baseball; and races. The hospital that carries out such a program will have a special director in charge.

Nursing Responsibilities.

1. Have the patient in proper dress for all activities—correct amount of clothing as to warmth and weight; rubbers if the ground is wet; in special gymnasium suits if these are used and kept on the ward.
2. Know your particular obligations—what to do, how to do it, what results to expect, and possible unfavorable reactions.
3. Be alert to early signs of fatigue—lack of interest, irritability, carelessness, hilarity, confusion.
4. Pay attention to physical and mental reactions.
5. Draw the physician's attention to any undesirable symptoms.
6. Have records up to date.

Recreational Therapy. *Meaning.*—Recreation is a form of occupation. In recreation there is less emphasis on effort and achievement than on pleasure and diversion; specific goals in regard to accomplishment are not primary factors.

Values.—During recreation mental tension is released, thoughts are taken away from self and directed toward reality, energy is used in a constructive way, and a better attitude toward others is developed.

Objectives.—Objectives in recreation are to help the patient relax and to establish a balance in biological needs. Many patients cannot relax and have had very little play during their entire lives—"All work and no play makes Jack a dull boy."

Types.—Types of recreation are active and passive. In the former the patient takes an active part, *e.g.*, in community singing, table games, or croquet. In the latter the patient has a passive part, *e.g.*, in movies, listening to music, or attending entertainments.

Activities.—Recreational activities consist of entertainments (parties, concerts, plays, exhibitions, and fairs); games (quiet games such as board games, cards, checkers, chess, dominoes, and picture puzzles, or active games such as billiards, bowling, ping-pong, pool, and ringtoss); light sports (badminton, croquet, golf,

horseshoe pitching, swimming, and tennis); and theatricals (pantomime, acting, and puppet shows).

Physiotherapy.—The physiotherapy department deals with the use of physical medicine—heat, light, and water. For an extensive program there should be a person in charge who has done special study in this field. From a nursing standpoint hydrotherapy, particularly wet-sheet packs and continuous baths, is one of the most important therapies. The wet-sheet packs and continuous baths are given only on a physician's specific order and according to a standard procedure.

Religious Activities.—People have spiritual needs. To meet this need hospitals (particularly those that house patients who are ill a long time) employ a chaplain to conduct services regularly and to contact patients. Family pastors are welcomed. All religious activities are under the direction of the medical department.

The nursing personnel is largely responsible for initiating and stimulating interest in the church service, letting the hospital chaplain know of particular wishes or needs (the matter is first taken up with the ward physician), seeing that the patient is contacted by the church prior to death if desired by the patient or the family or required by the patient's particular religious faith, and supplying the music. For suggestions, see Appendix III, page 328.

Spiritual matters are deep, very personal, and highly emotional. Never offer advice. Keep away from religious topics in conversation. However, inform the ward physician and the chaplain as to what takes place. Also, appreciate that you give indirect spiritual support when you believe that life is worth living and that there are satisfactory answers to such perplexing problems as why we live and why we suffer, in other words, when you yourself have established a working philosophy regarding life.

Bibliotherapy. Meaning.—With bibliotherapy the patient reads selected, prescribed material. He reads under a physician's direction, and the physician has the patient read special articles or books for a particular reason.

Material.—The reading material for bibliotherapy is selected for the patient and bears on his particular needs.

Purpose.—The purpose of bibliotherapy is therapeutic. The selected material helps the patient to understand himself and his

particular problems. It may be evaluated as to whether it gives information on wholesome living; tells about mental hygiene; suggests sound principles of conduct; provides answers for meeting a fundamental need (the patient identifies himself with a particular character); draws attention to special character or personality problems -timidity, aggressiveness, selfishness, inability to compromise; or stimulates an interest for which the patient has a special aptitude.

Hospital Library. —The hospital library is of two units—medical and general.

The medical section of the library is for the staff. Material is used by patients only through a physician's prescription. Usually the physician leaves the prescription on the ward, and the material is obtained for the patient by the ward.

Patients should have free access to the general library section. This part has a definite place in the total therapeutic scheme, providing it is established to meet therapeutic needs.

All reading material should be selected; that is, the source of supply should not be discards from the attics of well-meaning people. The reading matter should meet the best library standards, and current material should be new and up-to-date.

The librarian should meet special qualifications. This person should have made a special study of library work and have a satisfactory personality, particularly an ability to get along with people. The librarian should also have knowledge of people as well as books and some experience with medical aspects of the library.

Nursing Responsibilities.

1. See that the patient receives the material prescribed or suggested by the physician.
2. Stimulate the patient's interest in the use of the library.
3. Know the library facilities and acquisitions.
4. Inform patients regarding new or interesting material.
5. See that the patient gets to the library according to the hospital regulations or that material is brought to the ward.

The nurse should never recommend reading of any kind without first consulting the ward physician.

Resocialization. *Need.*—Generally speaking the person who is mentally ill thinks chiefly about himself. He keeps away

from others, or, if he is in their midst, he disturbs them. This barrier in social relationships has to be broken down, and the patient must learn to function adequately and harmoniously as a unit of the social group.

All purely social activities should be as nearly normal as possible—tea dances at tea time; social dances in the evening require special grooming. The nursing personnel wear clothes appropriate to the occasion and the need. The patient's presence places restrictions on dress; for example, in playing tennis you may discard the uniform, but it is not wise to dress as you might when playing with a friend in your own back yard.

In dealing with a patient always formulate the specific objectives for the particular activity; never lose sight of them. You may be playing a game of tennis, but your first responsibility relates to the *patient's therapeutic need*.

Method.—The general idea is to help the patient to reduce his interest in himself and extend his thinking, his affect, and his activity to include others—a necessary requisite for personal happiness. The hospital does not make great ado about socializing, or resocializing, the patient; it is all a part of the planned program of treatment and care.

The general regime in a hospital for the mentally ill is high in social values. Relatives are often upset because the patient does not have a private room; but the group life on the ward is a socializing experience and designed to meet a therapeutic need. Cooperation in social living is stressed, social adaptation is encouraged, and normal social adjustment is developed. Class activities are helpful, and there are special group activities which require or demand social contact.

Ward.—Patients are divided largely according to conduct; in other words, the behavior of the patient from a social point of view determines the group with which he is placed. When the patient cannot conform to the needs of a particular group, he is not well enough to be with that group; and, if he is removed, he should be told exactly why and what is expected of him in order to return.

When patients are transferred from one ward to another, be especially careful not to allow personal feelings to bias the information given to the physician.

Bulletin Board.—Every ward should have a bulletin board. Patients as well as personnel may contribute; however, all material goes first to the head nurse who consults with the ward physician.

A bulletin board should give information on coming events—movies, ball games, special radio programs, and entertainments. It should also be used for items of special interest—new books in the library; important news—world, national, state, and local; names of patients sufficiently improved to leave the ward or leave the hospital; names of new personnel. The bulletin board offers opportunity for recognition of patient achievements or notification of events that provide unusual pleasure—names of contest winners; announcement of birthdays, the wedding of a daughter, or the birth of a grandchild.

The posting of such information on a bulletin board tends to initiate interest in group activities, to stimulate interest of members in each other, and to furnish topics for wholesome conversation.

Planned Activities—To begin with, planned activities are usually on a recreational plane and gradually progress toward those that provide industrial and social usefulness. The very first step in resocialization may be through a plant, a piece of wood, or a bird—something outside of the patient's self.

Activities that help particularly in resocialization are the following:

Athletic events

Arranging special activities—tea dances, holiday activities, surprise parties; making favors for trays

Card parties

Community singing

Concerts

Contests (Competitive activities have an important place but require wisdom and close observation, as emotional reactions to success and failure are definite signs of illness or health; competitive activity is carried on first between patients and personnel.)

Dancing—square dances, folk dances, tea dances, evening dances with refreshments

Discussions on interesting subjects—birds, trees, current events, new books (These activities should be planned with assignments in advance so that patients have a chance to collect,

organize, and prepare material. The physician gives advice as to what topics can be discussed and which patients should participate.)

Dining room—make meals as pleasant as possible

Dramatics

Excursions to various places on the hospital grounds, local industries, and about town

Field-day activities

Games

Hobby shop

Hospital publication

Industrial activities

Music—provides a point of contact, makes people feel more friendly toward each other

Parties

Picnics

Reading aloud in small groups

Riddles

Religious services

Storytelling

Taffy pulls

Ward relationships

Formal Education. *Satisfaction in Ideas.*—Ideas prevent boredom, increase personal efficiency, and provide pleasure and satisfaction. Almost any purposeful activity can be developed into an intensive educational project.

Some hospitals carry on a definite educational program with organized academic classes; others bring in speakers. Even a small community can offer much in the way of worth-while material; the hospital personnel and patients themselves can contribute to such a program.

People in the community—personnel from art museums, museums of natural history and schools, members of music clubs, or people who have special hobbies are always willing and glad to give talks or short courses on their particular field (especially if there is remuneration); even the housewife with five children is happy to bring forth her university knowledge and share her special interest with others. Besides meeting a contributory therapeutic need, this helps to improve public relations and to give people a better understanding of the person who is mentally ill.

Educational Subjects.—An educational program has an academic aspect. A few suggestions for subjects are the following:

- Art
- Astronomy
- Business trends
- Ceramics
- Commercial activities, particularly typing
- Creative writing
- Current events
- Cooking
- Drawing
- Dressmaking
- Geology
- Housekeeping
- Literature
- Mathematics
- Music
- Photography

These general subjects can be broken up further. The approach to the study of literature may be through poetry; the novel; a nationality—American, Russian, Scandinavian; a special kind of literature—European classics, American novel; or a particular period. The study of music may be considered from the following angles: a conception of music for the wholly inexperienced listener; predominant musical patterns—rhythm, melody, harmony, form; the study of musical forms—march, overture, rondo, scherzo, suite, canon, fugue, concerto, theme with variations, the psalm, the mass, cantata, oratorio, symphonic poem, symphony: simple methods of participation; the study of a particular instrument; or a special approach—musical values, logic, interpretation, the analysis of a composition.

Social Service Activities.—Regarding the treatment of the patient as a whole, social service is concerned chiefly with social aspects. The social worker deals with the patient, the family, and the community. She is a social therapist. For details of her work, see "Annual Report of the Committee on Mental Hospitals," American Association of Psychiatric Social Workers, 1932-34, pages 7 to 17. This compilation of essentials is also recorded in "Administrative Psychiatry" by William A. Bryan, page 210 ff.

organize, and prepare material. The physician gives advice as to what topics can be discussed and which patients should participate.)

Dining room—make meals as pleasant as possible

Dramatics

Excursions to various places on the hospital grounds, local industries, and about town

Field-day activities

Games

Hobby shop

Hospital publication

Industrial activities

Music—provides a point of contact, makes people feel more friendly toward each other

Parties

Picnics

Reading aloud in small groups

Riddles

Religious services

Storytelling

Taffy pulls

Ward relationships

Formal Education. *Satisfaction in Ideas.*—Ideas prevent boredom, increase personal efficiency, and provide pleasure and satisfaction. Almost any purposeful activity can be developed into an intensive educational project.

Some hospitals carry on a definite educational program with organized academic classes; others bring in speakers. Even a small community can offer much in the way of worth-while material; the hospital personnel and patients themselves can contribute to such a program.

People in the community—personnel from art museums, museums of natural history and schools, members of music clubs, or people who have special hobbies are always willing and glad to give talks or short courses on their particular field (especially if there is remuneration); even the housewife with five children happy to bring forth her university knowledge and share her special interest with others. Besides meeting a contributory therapeutic need, this helps to improve public relations and to give people a better understanding of the person who is mentally ill.

Educational Subjects.—An educational program has an academic aspect. A few suggestions for subjects are the following:

- Art
- Astronomy
- Business trends
- Ceramics
- Commercial activities, particularly typing
- Creative writing
- Current events
- Cooking
- Drawing
- Dressmaking
- Geology
- Housekeeping
- Literature
- Mathematics
- Music
- Photography

These general subjects can be broken up further. The approach to the study of literature may be through poetry; the novel; a nationality—American, Russian, Scandinavian; a special kind of literature—European classics, American novel; or a particular period. The study of music may be considered from the following angles: a conception of music for the wholly inexperienced listener; predominant musical patterns—rhythm, melody, harmony, form; the study of musical forms—march, overture, rondo, scherzo, suite, canon, fugue, concerto, theme with variations, the psalm, the mass, cantata, oratorio, symphonic poem, symphony: simple methods of participation; the study of a particular instrument; or a special approach—musical values, logic, interpretation, the analysis of a composition.

Social Service Activities.—Regarding the treatment of the patient as a whole, social service is concerned chiefly with social aspects. The social worker deals with the patient, the family, and the community. She is a social therapist. For details of her work, see "Annual Report of the Committee on Mental Hospitals," American Association of Psychiatric Social Workers, 1932-34, pages 7 to 17. This compilation of essentials is also recorded in "Administrative Psychiatry" by William A. Bryan, page 210 ff.

When patients are admitted to the hospital, the social service worker interviews the relatives and compiles a social history, especially the history of the illness, which enters into diagnosis, treatment, and, later, parole. Occasionally the patient cannot return home because of conflicts or barriers. In such cases the social worker contacts friends or employers and makes plans for a parole.

If a patient worries about home or community matters, take the problem up with the social service department. It is sad to see patients stew over legitimate responsibilities that they themselves cannot meet.

Quite often patients suddenly are brought to the hospital, leaving clothing, furniture, and personal effects without anyone in charge. If there is much personal property, a guardian is appointed. If the situation does not require a guardian, the social service worker contacts relatives or an agency and arranges for the storing or care of such things until the patient leaves the hospital.

Men worry over bills; business matters that should be transferred to someone else; or a present for a grandchild's birthday. Women worry over getting the winter clothes mended, dry-cleaned, and put away for the summer; and about whether little Mary gets her milk each afternoon or whether twelve-year-old John goes to bed at the proper time.

Relatives may visit the hospital, and patients may write letters; but even so sometimes comparatively small matters become acute problems in the life of the patient. When anything unpleasant occurs, relatives usually consider that they should spare the patient and either do not answer the specific question or dodge the issue in some way.

When patients worry, it is your responsibility to meet the problem either by dealing with it directly or seeing that it reaches the right person.

The social service department and the nursing service are not obliged to work together as closely as some other departments in the hospital organization; however, they both need a better understanding of the function and problems of the other's field and particularly the way in which they can help each other to help the patient.

NURSING CARE: SPECIAL POINTS

Emphasis According to Treatment Units.—The following wards are considered: admission, medical and surgical, infirmary, disturbed, quiet, convalescent, and research. The names of the wards indicate the patient behavior or the ward activity—particularly the treatment aspect.

Admission Ward.—On the admission ward the emphasis in nursing care relates to suicide, rapport, nursing skills, sleep, and habit training.

The rate of suicide on admission wards is high. Watch for suicide regardless of "first impression" diagnosis; the physician's advice is often from speculation only, and information regarding potential suicide is sometimes hidden for the first few days. In such matters you carry a full share of responsibility; do not feel content because a patient's name is not placed on a suicidal list.

When the patient has just been admitted is the time to stress building rapport. Welcome the patient, orient him to the hospital, spend time getting acquainted. To project your own feeling state of sincere interest in the patient's welfare (transfer of feeling tones) is an important duty.

Activities relating to admission routines and diagnostic measures make heavy demands on nursing skill.

The admission ward offers a real test of your ability to put a patient to sleep; the newly admitted patient is especially fearful because of his strange surroundings. Your own general attitude and behavior comprise the strategic tool.

Habit training receives emphasis on the admission ward. The patient needs to be placed in an environment in which his energy is not allowed to be dissipated and left at loose ends. Living with a purpose is paramount; habit training is an initial step.

Medical and Surgical Wards.—These wards house the patients with physical illnesses such as pneumonia and diabetes, as well as those who have undergone operations—appendectomy, cholecystectomy, gastroenterostomy, and brain surgery.

These patients require psychiatric nursing care, but on the whole these wards are not unlike the wards in the general hospital. The physical condition of the patient and the amount of individual attention required reduce psychiatric nursing problems.

Special problems in the medical and surgical wards relate to dressings and isolation. Regarding dressings, the problem is to keep the patient from removing them. Several layers of cotton and collodion are the dressing of choice, especially for small areas. Sometimes the physician deems it best to use sedation for a few days until the healing process begins. Isolation is a real problem. Germicidal solutions cannot be left around, and it is much more difficult, sometimes impossible, to have definite "clean" and "unclean" areas. Aside from the segregation of the patient, any attempt at actual isolation technique requires "specializing."

Infirmary.—These are the wards housing the aged; treatment and care are largely custodial. From an administrative point of view these wards are costly. The patients are often bedridden or not able to take care of themselves and require a great deal of individual attention. A high degree of special study is not imperative.

Disturbed Ward.—On the disturbed ward the emphasis in nursing care is on hygienic measures; habit training; nursing skills—particularly continuous baths, wet-sheet packs, shock therapy; prevention of combative and destructive behavior; and protection. On this ward the patient has the least personal freedom. There are more locked doors and special windows from which he cannot escape; there is a noticeable lack of luxury. The general idea is to protect the patient from his own unwise behavior.

There is a difference in the treatment and care of those who are acutely disturbed and those who are chronically disturbed. With the acutely disturbed the measures are conservative; with the chronically disturbed the measures are more drastic, or seem so, because it takes more effort to push the patient into taking part in any activity.

The nursing care on a chronic deteriorated disturbed ward is almost wholly that of habit training and protection (custodial). On such wards do not be discouraged. Usually there are a few patients whose behavior can be modified. To see a patient leave the hospital and earn his own living after a stay of some fifteen years is just as thrilling as to see larger numbers leave the hospital from the wards for patients who are acutely ill.

Quiet Ward.—The admission ward is active with hospital routines; the medical and surgical wards are not unlike those in the general hospital; the disturbed wards have a great deal of

excitement and prescribed activity; but it is in the quiet ward that you experience "a let down" in physical activity, largely because the patient does things for himself and has many activities off the ward. The quiet ward is where the patient begins to have energy to use in a constructive way.

The objectives on the quiet ward are to have the patient use energy in a constructive way and to establish a balance in work, play, rest, and faith. For the most part the patient on the quiet ward can take care of himself. The stress is on personal routine and a rhythmic pattern of activity. When a program for the required daily activity has been established, more energy is left for responsibilities and effective work, which in turn give zest to living.

Specific nursing responsibilities on the quiet ward are the following:

1. Direct the energy released by treatment into wholesome channels.
2. Help the patient build himself toward a satisfactory status—physical, mental, social, spiritual, and economic. The quiet ward is where the mending process, the restoration, and the rehabilitation take on an active form. In meeting your responsibilities here, you will use your head more than your hands.

On the quiet ward there are two groups of patients—those who were psychotic and have been transferred from a disturbed ward and those who have psychoneurotic symptoms. With both groups the emphasis in treatment and care is on psychiatric aspects. Very likely the physicians are carrying on intensive psychotherapy with all patients, helping them to gain insight into their condition and to understand why it occurred and how it can be avoided in the future. The patient is still not well, and patient-nurse relationships can disturb his equanimity or make difficulties in relation to the deep therapy treatment.

Under these conditions you should be especially cautious and weigh everything you say or do. Even then you will make mistakes. You have a very difficult time. You are expected to push the patient toward normal activities, and yet you must not take a step on your own. In addition, the patient is troubled and trying to crystallize ideas within his own mind. He will ask you

the very questions you should not attempt to answer but may unwittingly, because the important question will be masked by several others shot at random.

If you do an active piece of work, you will make mistakes; but it is more important that you be sensitive to mistakes and avoid repetitions if possible. Your help comes from conferences with the physician. Usually these conferences are held regularly at established hours, and the physician, instructor, supervisor, head nurse, and students dealing directly with the patient are all present. Speak freely regarding interpersonal relationships and your particular effort, especially your approach to the patient in specific situations.

Convalescent Ward.—For some reason it seems difficult to appreciate the nurse's role in the convalescent ward. Perhaps it is because there are few specific orders and no detailed account of nursing care, and because the patient is your equal in the plan you endeavor to stimulate and conduct.

You are most apt to fall short in both quantity and quality of nursing care on the convalescent ward. Too often the real joy is experienced with the very sick patient, and the person on the convalescent ward appears too well to be interesting. There is still work to be done.

The objectives on the convalescent ward are as follows: There should be a *complete* health program for the patient—a program that meets the needs of body, mind, and spirit. The patient is expected to have resources under command and integrated around definite purposes, to select and direct his own activities, and to contribute to group life.

The patient on the convalescent ward spends his time in purposeful, useful work. Work, rest, and fun are all in balanced proportion. There are no locked doors, and the patient has a great deal of freedom; in fact, he is pretty much on his own. He assumes more initiative regarding his plan for daily living and institutes his own program of personal hygiene. He not only takes care of himself, but he is beginning to use his energy in doing for others. He makes a fine person to consult and seek for aid in planning and carrying out group activities. If he has the capacity, he is slowly made a leader of a small group.

On the convalescent ward the patient's physician continues with intensive psychotherapy, particularly in relation to preventive

measures. Nursing care is provided but should not be evident. Your real duty is to help the patient to help himself.

Additional nursing points for the convalescent ward are the following:

1. Have objectives clearly in mind. If objectives are not clear, very little nursing care will be carried out. The patient does so much for himself that it is easy to let him go his own way.
2. Stimulate self-impetus. If there is no inner drive toward definite goals, you can "get by" by doing very little for the patient; but the development of your capacity for the psychiatric aspects of care will be hampered.
3. Watch for suicide. Suicide is always an important problem on a convalescent ward, especially with patients who have been depressed.

On the convalescent ward, as on the quiet ward, nursing care is predominantly on psychiatric aspects; specific guidance comes from the physician.

Research Ward.—Here treatment and care are intensive and highly specialized. The patient-personnel ratio is at its best. Know the physician's particular wishes in dealing with a patient, and be especially careful in reporting every detail.

Energy Requirements (of the Nurse).—In a hospital for the mentally ill there is considerable variation in the kind of energy you are obliged to use. Activities are not constant. Wards operate at different levels, and the patients on a ward are often at different levels of treatment. Usually a fair amount of physical and mental energy is exacted; however, on certain wards and in single situations one or the other often predominates.

Mental Energy.—In purely psychiatric aspects of nursing the demand on mental energy is heavy. You will discover that your head is a greater instrument of service than your hands. Responsibilities include the following:

1. Formulate objectives. Ultimate objectives remain more or less constant, but immediate objectives change with each situation.
2. Constantly weigh immediate versus ultimate objectives.
3. Think in terms of qualities and values.

4. Give continual thought to the meaning of this or that behavior.
5. Penetrate into subjective aspects of behavior—the patient's thoughts and feeling state of the moment (this may be quite different from that which is indicated by what he says or does; in fact, it is often just the opposite).
6. Look for cause-and-effect relationships.
7. Speculate on subsequent behavior.
8. Evaluate unusual behavior.
9. Be aware of fear.
10. Be quick to notice frustration.
11. Appreciate emotional needs, particularly in relation to environmental situations.
12. Recognize a lack of wisdom in the management of interpersonal relationships from a standpoint of treatment objectives.

Admission Ward.—The admission ward requires about equal expenditure of physical and mental energy. Admission routines and diagnostic measures are many. Demands on mental energy are great. You must be alert every second for signs of possible suicide, evaluate the patient's behavior and study his particular behavior reactions, and see him in relation to others. In addition, it is your special responsibility to make the patient glad that he is in this particular hospital and help him to sense that he is where he will be helped.

Medical and Surgical Wards.—On these wards the use of physical energy predominates, although mental-energy requirements are greater than on similar wards in a general hospital, largely because you should have a greater capacity to recognize the need for, and deal with, psychiatric aspects of care.

Infirmary.—Here the demands are more on physical energy.

Disturbed Ward.—On a disturbed ward you should use just as much mental as physical energy; however, the large amount of physical energy required (and from which there is no escape) keeps you from feeling at a loss in dealing with the patient if you are not familiar with detailed psychiatric aspects of care.

Quiet Ward.—On this ward you begin to realize the value of purely psychiatric aspects of nursing and the use of mental energy as something apart from the use of physical energy.

Convalescent Ward.—On the convalescent ward your output of energy is almost wholly mental.

Evaluation of Care. Criteria for Quality in Nursing Care.

1. Sleep.
 - a. Sleep without sedation.
 - b. Reduction in sedatives and hypnotics. (This is a specific criterion regarding *quality* in nursing care.)
2. Aggressive, unwholesome behavior—there should be reduction in
 - a. Anxiety, fear.
 - b. Combative behavior.
 - c. Destructive tendencies.
 - d. Emotional tension.
 - e. Explosive behavior (schizophrenic reaction).
 - f. Idleness.
 - g. Noise.
 - h. Preoccupation.
 - i. Restlessness.
 - j. Uncooperative behavior.
 - k. Untidiness, bad sex habits.
 - l. Violent outbursts (manic).
3. Interpersonal relationships.
 - a. Satisfactory affective relationships.
 - b. Tranquility in the emotional atmosphere of the ward.
 - c. Absence of unnecessary emotional upsets.
4. Physical health.
 - a. Restoration of appetite.
 - b. Increase in weight.
 - c. Proper elimination; no fecal impactions.
 - d. Sufficient amount of fluids.
 - e. Muscular relaxation.
5. Accidents—at a minimum.
6. Escapes—few.
7. Suicides—none.

Evidence of Poor Nursing Care.

1. Much sedation.
2. Inactivity.
3. Isolation.

4. Restraint.
5. Aggressive behavior out of hand.
6. Untidy, degenerate appearance.
7. Constipation, fecal impactions.

Teaching Psychiatric Nursing.—Key points in teaching psychiatric nursing, or psychiatric aspects of nursing, are the same principles that apply in all teaching, namely: The instruction should be *student-centered*. Motivation should be the chief medium of instruction. The process is dominantly one of learning, not teaching. Progress is rated in adaptability to new situations and problems.

In psychiatric nursing the central problem has to do with human relationships, and care is oriented to the patient as a person. Stress is placed on the reality and philosophy of nursing. Knowledge, understanding, kindliness, objectivity, and tenderness represent the cornerstone of technique; but these must be further expanded and elucidated until an area for concentrated effort is provided.

REFERENCES

BOOKS

- American Medical Association: "A Handbook of Nutrition," American Medical Association, Chicago, 1943.
- BOGERT, L. JEAN: "Nutrition and Physical Fitness," 4th ed., W. B. Saunders Company, Philadelphia, 1943.
- BRYAN, WILLIAM A.: "Administrative Psychiatry," W. W. Norton & Company, Inc., New York, 1936.
- DAVIS, JOHN E. and WM. R. DUNTON: "Principles and Practice of Recreational Therapy for the Mentally Ill," A. S. Barnes & Co., New York, 1936.
- DAVIS, JOHN E.: "Play and Mental Health," A. S. Barnes & Co., New York, 1938.
- DAVIS, JOHN E.: "Principles and Practice of Rehabilitation," A. S. Barnes & Co., New York, 1943.
- HAAS, LOUIS J.: "Practical Occupational Therapy for the Mentally and Nervously Ill," The Bruce Publishing Company, Milwaukee, 1944.
- HAWORTH, NORAH A. and E. MARY MACDONALD: "Theory of Occupational Therapy," 3rd ed., The Williams & Wilkins Company, Baltimore, 1946.
- HILTNER, SEWARD: "Religion and Health," The Macmillan Company, New York, 1943.
- MASON, BERNARD and ELMER MITCHELL: "Social Games for Recreation," A. S. Barnes & Co., New York, 1935.
- MILLER, N. E. and J. DOLLARD: "Social Learning and Imitation," Yale University Press, New Haven, 1941.

- MITCHELL, E. D. and B. S. MASON: "The Theory of Play," A. S. Barnes & Co., New York, 1935.
- RIGGS, A. F.: "Play—Recreation in a Balanced Life," Doubleday, Doran & Company, Inc., New York, 1935.
- RUSSELL, JOHN I.: "The Occupational Treatment of Mental Illness," William Wood & Company, Baltimore, 1938.
- WILLIAMS, JESSE F.: "Principles of Physical Education," 2nd ed., W. B. Saunders Company, Philadelphia, 1932.
- WISE, CARROLL A.: "Religion in Illness and Health," Harper & Brothers, New York, 1942.

ARTICLES

- ALPERT, DAVID B. "Religion and State Hospital," *Mental Hygiene*, October 1943, pp. 574-580.
- BAKER, GRACE. "The Relation of Occupational Therapy and Psychiatry," *Occupational Therapy and Rehabilitation*, February 1939, pp. 19-23.
- BIGELOW, NEWTON J. T. and EVA M. SCHIED. "The Therapeutic Promise of Foster Family Care for the Mentally Ill," *The Psychiatric Quarterly*, January 1939, pp. 16-32.
- BURLINGAME, C. C. and C. P. WAGNER. "The Psychiatric Hospital as an Institute of Learning," *The Journal of the American Medical Association*, November 9, 1935, pp. 1509-1512.
- CHITTICK, RUPERT. "Occupational Therapy in Its Relation to a Program of Mental Treatment," *Occupational Therapy and Rehabilitation*, August 1939, pp. 231-234.
- CHOATE, ALLYN B. "Family Situations and Mental Hygiene," *The Family*, January 1938.
- COOKE, DOROTHEA. "Industrial Therapy as Applied in an Occupational Therapy Department," *Occupational Therapy and Rehabilitation*, February 1936, pp. 31-39.
- DAVIS, JOHN E. "Recreation in the Mental Hospital," *Mental Hygiene*, January 1942, pp. 85-91.
- DAVIS, JOHN E. "Practical Objectives in Physical Education in the Treatment of the Mentally Ill," *The Psychiatric Quarterly*, April 1935, pp. 237-262.
- DAVIS, JOHN E. "Utilization of Play in Construction of Healthy Mental Attitudes," *Mental Hygiene*, January 1936, pp. 49-54.
- FAVER, HARRY E. "Function and Purpose of Occupational Therapy," *Occupational Therapy and Rehabilitation*, August 1944, pp. 159-167.
- FITZSIMMONS, LAURA W. "Handicrafts," *The American Journal of Nursing*, February 1938, pp. 147-152.
- GROSSMAN, MAURICE. "Principles and Practice of Occupational Therapy," *Medical Bulletin of the Veterans' Administration*, October 1941, pp. 182-196.
- HINSIE, LELAND. "Psychiatric Implications in Occupational Therapy," *The Psychiatric Quarterly*, October 1937, pp. 544-551.
- KAMM, A. "Recreation: Therapeutic Value," *Occupational Therapy and Rehabilitation*, August 1940, pp. 237-245.

- KELLOGG, CHARLOTTE. "An Institute of Living," *Atlantic Monthly*, March 1935, pp. 325-334.
- KILGOUR, A. J. "Colony Gheel," *The American Journal of Psychiatry*, January 1936, pp. 959-965.
- MENNINGER, WILLIAM C. and ISABELLE MCCOLL. "Recreational Therapy as Applied in a Modern Psychiatric Hospital," *Occupational Therapy and Rehabilitation*, February 1937, pp. 15-23.
- MOHR, GEORGE J. "Mental Hygiene Aspects of Occupational Therapy," *Occupational Therapy and Rehabilitation*, February 1939, pp. 25-30.
- OBERNDORF, C. P. "The Nature of Psychogenic Cure," *The American Journal of Psychiatry*, July 1944, pp. 91-96.
- PENTREATH, E. and E. DAX. "Mental Observation Wards: A Discussion of Their Work and Its Objects," *The Journal of Mental Science*, July 1937, pp. 347-365.
- POLLOCK, HORATIO. "The Family Care System of Scotland," *Mental Hygiene*, July 1936, pp. 414-423. (For the Scotch system of placing mental patients in private homes, see also *The American Journal of Insanity*, April 1869, p. 499; and 72nd Report of the Friends' Retreat, York.)
- QUINT, MARY D. "The Mental Hospital Library," *Mental Hygiene*, April 1944, pp. 263-272.
- RUFFINI, ELSIE. "Creative Occupational Therapy," *The American Journal of Nursing*, September 1936, pp. 883-889.
- SCHLUSSEL, M. J. "Occupational Therapy in Hospital Ward," *Occupational Therapy*, April 1942, pp. 102-104.
- SEARLE, W. FREDERICK. "Art Classes with Mental Patients," *Mental Hygiene*, January 1943, pp. 63-69.
- SELLING, LOWELL S. "The Role of Food in Psychiatry," *Diseases of the Nervous System*, December 1944, pp. 365-368.
- SHULAK, NORMAN R. "Occupational Recreation Programs in Neuro-psychiatric Sections of Army Station Hospitals," *War Medicine*, February 1944, pp. 109-117.
- SOLOMON, JOSEPH G. "Active Play Therapy," *The American Journal of Orthopsychiatry*, July 1938, pp. 479-498.
- SPOORS, ELIZABETH J. "Mental Patients Read? They Will," *Hospitals*, November 1945, pp. 80-82.
- WOODWARD, LUTHER E. "Mental Hygiene Problems in Vocational Rehabilitation," *Journal of Rehabilitation*, March 1945. (Rehabilitation of veterans.)
- WOOTTON, L. H. and L. MINSKI. "A Rehabilitation and Resocialization Scheme for Psychopathic Patients," *The Journal of Mental Science*, January 1940, pp. 60-65.

CHAPTER VIII

NURSING CARE: SECONDARY PERSONALITY CHANGES

Primary Physical Diagnosis.—With secondary personality changes there is always a primary physical diagnosis; a psychosis develops when the pathologic process is diffuse, or when it affects the cortex of the brain. (The cortex of the brain lies closest to the skull and is concerned with the higher levels of function.) Although the personality symptoms are secondary, they are not wholly explained on the basis of the primary physical diagnosis; no doubt the psychological effect of the illness enters into the picture, and some of the symptoms are an adjustment to a changed capacity. The advent of abnormal mental reactions means that more of the person has become involved.

Symptoms.—The symptoms of the secondary personality changes are evident as modifications of primary personality disorders. In general, changes are observed in the physical field, the sensorium and intellectual reactions, and the personality.

Physical Field.—These changes relate to the organic pathological process. Outstanding symptoms are pain (often not present in neurological conditions); changes in pulse, respiration, blood pressure, sensation, and motor responses—motor weakness, faulty coordination, slow, deliberate movements, movements increased in speed, twitching and jerking of muscles, seizures, unsteady gait, and decreased or increased speed in locomotion.

Sensorium and Intellectual Reactions.—These changes are noticeably disturbances in consciousness ranging from bewilderment to disorientation; and diminution of higher mental function—impairment in memory, calculation, reasoning, and judgment.

Personality.—These changes are, particularly, emotional instability, deterioration of personal habits, indiscreet behavior (judgment defect), and changes in mood and attitudes. Compared to primary personality disorders, the changes in mood and attitude are not so marked, not so deep, not so rigid, and more easily recognized as relating to personality characteristics in health.

Early Symptoms.—The early symptoms of these conditions are seen quite often on the medical and neurological wards and in outpatient departments, but rarely on the psychiatric ward. The person does not arrive on the psychiatric ward until the mental manifestations are sufficiently marked to make living in the community impossible or unwise. Headache, irritability, confusion, forgetfulness, or any change in general behavior points to a disorder of the central nervous system.

Acute and Chronic Conditions. *Acute.*—Here the onset is sudden. The condition is temporary and clears up quite quickly. It is usually a toxic condition.

Chronic.—Here the onset is generally insidious. The condition is irreversible and shows progressive dementia. It is based on known organic pathological conditions.

Treatment.—In general this includes specific treatment of the primary physical condition, symptomatic treatment, supervision of the dietary, palliative treatment, attention to concurrent behavior problems, and protection (custodial).

Nursing Care.—From a purely psychiatric point of view, nursing care of patients with secondary personality changes is chiefly the application of principles used in treating those with primary personality disorders. Detailed points are the following:

1. In caring for patients suffering from bewilderment or disorientation, protect against injury. Reduce and manage the state of fear—be calm, quiet, poised; diminish noise; give verbal assurance; do not talk much, say only a few words at a time; provide proper lighting (have sufficient light, as shadows increase fear); supply information on the place and the people around the patient; reduce number and changes in workers (the same voice and the same touch provide a feeling of security).

2. In dealing with patients with intellectual impairment, recognize and consider the level of intellectual functioning; protect and help particularly regarding memory defect, faulty judgment, and aggressive behavior. In general, definite orders for specific treatment relating to the primary physical diagnosis fill the day.

In all branches of nursing there is an effort to care for the patient as a whole; however, with each approach there must be an emphasis on certain aspects.

In the care of people suffering with primary personality disorders the emphasis is on psychological, social, and philosophical

angles, specifically on moods, attitudes, and symbolization. With those who show secondary personality changes, the primary emphasis is placed again on concrete objective details—one of this, two of that, for so long a time.

Many of the conditions described in this section have a primary neurological basis. Neurological nursing is a particularly important field and gets too little attention, especially if combined with psychiatric nursing. As in all nursing, the neurological field may have psychiatric aspects, but actually it is not any more an integral part of psychiatric nursing than any other field.

Classification.—The following is a section from the revised classification of mental disorders taken from the tenth edition of the "Statistical Manual for the Use of Hospitals for Mental Diseases," prepared by the Committee on Statistics of the American Psychiatric Association, 1942.

Psychoses Due to, or Associated with, Infection.—Psychoses with syphilis of the central nervous system—meningoencephalitic type (general paresis), meningovascular type (cerebral syphilis), psychosis with intracranial gumma, other types; psychoses with tuberculous meningitis; psychoses with meningitis (unspecified); psychoses with epidemic encephalitis; psychoses with acute chorea (Sydenham's); psychoses with other infectious disease; postinfectious psychoses.

Psychoses Due to Intoxication.—Psychoses due to alcohol—pathological intoxication, delirium tremens, Korsakoff's psychosis, acute hallucinosis, other types; psychoses due to a drug or other exogenous poison—psychoses due to a metal, psychoses due to a gas, psychoses due to opium or a derivative, psychoses due to another drug.

Psychoses Due to Trauma (Traumatic Psychoses).—Delirium due to trauma, personality disorders due to trauma, mental deterioration due to trauma, other types.

Psychoses Due to Disturbance of Circulation.—Psychoses with cerebral embolism, psychoses with cerebral arteriosclerosis, psychoses with cardio-renal disease, other types.

Psychoses Due to Convulsive Disorder (Epilepsy).—Epileptic deterioration, epileptic clouded states, other epileptic types.

Psychoses Due to Disturbances of Metabolism, Growth, Nutrition, or Endocrine Function.—Senile psychoses—simple deterioration, preschizophrenic type, delirious and confused types, depressed and agitated types, paranoid types; presenile sclerosis (Alzheimer's disease); involutional psychoses—melancholia, paranoid types, other types; psychoses with

glandular disorders; exhaustion delirium; psychoses with pellagra; psychoses with other somatic disease.

Psychoses Due to New Growth.—Psychoses with intracranial neoplasm; psychoses with other neoplasm.

Psychoses Due to Unknown or Hereditary Cause But Associated with Organic Change.—Psychoses with multiple sclerosis; psychoses with paralysis agitans; psychoses with Huntington's chorea; psychoses with other disease of the brain or nervous system.

From the previous outline one infers that mental symptoms may appear with any illness; the nomenclature provides a general idea as to the primary cause.

Approach for Study.—In a study on psychiatric nursing, the secondary personality changes are not all considered singly; the time and the energy involved would be out of proportion to the value and the need. The following approach is suggested:

1. Review principles of care of patients with primary personality disorders.
2. Recognize and report any sudden change in pulse, respiration, or blood pressure; state of consciousness—drowsiness, stupor, or coma; and any signs of intracranial pressure or hemorrhage.
3. Review material on the primary physical diagnosis.
4. Investigate pathological process—type of pathology, particular part of the central nervous system involved, the extent of the involvement, the physiological significance. (See Gotten and Wilson's "Neurological Nursing," particularly Unit I, "Anatomy and Physiology.")
5. Add to present information: Examine textbook material on the specific condition; investigate reasons for particular treatment; know the desired effect and the possible dangers of any drug used; search for additional ideas—formulate questions and ask the head nurse for answers or where to find answers. (There is a fixed pupil—why? There is paralysis of the right eye and the left arm—why the right eye but the left arm? There is incontinence—why? With this last question investigate nursing care first.)

Specific Conditions.—The clinical groups or specific conditions discussed on the following pages are (1) psychoses with syphilis of the central nervous system, (2) psychoses with epidemic encephalitis, (3) alcoholic psychoses, (4) psychoses due to a drug or

other exogenous poison, (5) psychoses due to trauma, (6) psychoses with cerebral arteriosclerosis, (7) psychoses due to convulsive disorder, and (8) senile psychoses.

PSYCHOSES WITH SYPHILIS OF THE CENTRAL NERVOUS SYSTEM

Initial Infection.—This condition is the result of infection of the central nervous system by the syphilitic organism, spirocheta pallida (*treponema pallidum*); the extent is evidenced by the clinical picture. In this condition *there is always an initial infection of syphilis*.

Occurrence.—Clinical symptoms of syphilis of the central nervous system occur 2 to 40 years after initial infection. If untreated, about 25 per cent of syphilitic infections terminate in syphilis of the central nervous system. Involvement of the central nervous system is evident within 2 years after initial infection by examination of the spinal fluid.

Prevention.—Prevention consists in the elimination of syphilis, adequate treatment of initial infection, and early examination of spinal fluid.

Principal Types.—The principal types are meningoencephalitic (general paresis) and meningovascular (cerebral syphilis). These types are not completely separated; that is, both types may exist at the same time.

Meningoencephalitic Type.—Names given to this condition are psychoses with syphilitic meningoencephalitis; parenchymatous syphilis; general paresis; general paralysis of the insane; dementia paralytica; and paretic neurosyphilis. The names are divided into two groups—those that indicate the fundamental pathological process and those that indicate symptoms.

Condition.—This is a serious disorder and presents the chief psychotic form. The nerve cells, the essential or functional part, are affected; nerve cells destroyed are never replaced.

Occurrence.—This condition occurs 5 to 40 years following initial infection. It constitutes 5 to 8 per cent of admissions to the large hospitals for the mentally ill, about 5 per cent of all cases of syphilis of the central nervous system, and about .5 per cent of individuals infected with syphilis. The diagnosis is based on history, signs of physical and mental deterioration, signs of the destruction of nerve cells in the brain, and serology.

Prognosis.—The prognosis is favorable with intensive treatment, especially in prepatetic stage. (Prepatetic symptoms: beginning pupillary changes, physical complaints, marked fatigue, headache, dizziness, and forgetfulness.) Through intensive treatment there is improvement or arrestment of the disease process in about 33 per cent of patients. The disease process is considered arrested when the spinal-fluid tests are negative for one year. If the disease is untreated, there is progressive physical and mental deterioration.

Symptoms.—The early symptoms are insidious in appearance. They include slight impairment in mental faculties—forgetfulness, particularly regarding detail; faulty judgment; gradual changes in personality—carelessness, crudeness, irritability, emotional lability, indifference to important matters.

The condition is often first recognized by one of the following: an acute episode—tremendous spending spree without money to pay for the purchases; undertaking of more business projects than could be managed at one time; the occurrence of a seizure; or following a head injury.

When the clinical picture is established, symptoms are as follows: neurologic signs—pupils irregular or unequal, do not react to light but do react to accommodation (Argyll-Robertson); marked tremor in lips and tongue; speech disturbances (relate to paralysis in muscles of throat and mouth)—words slurred, syllables and words omitted, some words and phrases unpronounceable (test phrases are "Methodist Episcopal," "third riding artillery brigade," "around the rugged rock the ragged rascal ran"—this also tests memory); lack of facial expression; evident writing defect; seizures (sometimes present); and incontinence when the spinal cord is involved. The outstanding mental reactions are irritability; emotional instability; delusions; memory, reasoning, and judgment defect; and lack of insight after dementia begins.

From a mental point of view, the outstanding clinical types are the following: expansive—sense of well-being (euphoria) and delusions of grandeur that cause the patient verbally to shower everyone with diamonds, pearls, automobiles, and castles; depressive; agitated; and demented. Mental reactions often clear up after fever therapy; in such cases the mental reactions are occasioned by inflammation rather than destruction of cells.

As to laboratory findings, serology is always positive in untreated cases of syphilis. The blood usually shows a positive

Wassermann and Kahn reaction; negative reactions are seen in treated cases of syphilis. Examination of the spinal fluid shows the cell count increased, 10 to 200 cells per cc., the globulin greatly increased, Wassermann and Kahn reaction almost always positive; and a paretic curve (curve in first zone) in the colloidal-gold test.

Treatment.—The treatment used is usually fever therapy followed by administration of arsenicals and heavy metals; also medication to meet specific needs.

Methods of fever therapy are inoculation by malaria, apparently the method of choice, and typhoid, protein shock, artificial cabinet.

Of the arsenicals, tryparsamide is usually used; this is given intravenously. If contraindicated, one of the trivalent arsenicals, those which have a lower reacting power and less effect on the optic nerve, are used. Of the heavy metals, bismuth is generally the metal of choice; this is given intramuscularly and usually as bismuth salicylate in oil.

Insulin is often administered subcutaneously to increase appetite, and vitamins, particularly B₁, are given for vitamin deficiency. After mental symptoms appear, treatment is intensive and continuous for a long period—a minimum of 3 years.

Nursing Care.—Nursing care may be summarized as follows:

When there are abnormal *mental reactions*, apply principles used in the care of patients with primary personality disorders; learn about previous behavior reactions; avoid altercations; watch for assaultive and destructive behavior and for sudden violence. Appreciate that this type of patient is easily influenced by general atmosphere.

A sense of well-being (*cuphoria*) misleads the observer regarding the existence of a physical disorder.

The patient who has *poor judgment* will attempt anything; see that his efforts are in keeping with his energy and capacity.

When the patient is *overactive*, give plenty of fluids to prevent dehydration; appreciate that accident possibilities are increased.

The symptom of *confusion* is increased at night; furnish the necessary assistance and reduce feelings of insecurity.

If the patient has *seizures*, protect him from hazardous situations; watch carefully during and following seizure, as the patient may die at this time.

The patient with *paralysis of throat muscles* is apt to choke while eating, especially if he eats hurriedly and takes large mouthfuls. Cut the food into small pieces and assist by regulating the amount of food taken at one time—feed if necessary—and the length of time for chewing; and the speed with which the eating process is carried out.

Patients with *diminished sensibilities* do not complain of cold, heat, or of being hurt; burns (in contact with radiators), bruises, and physical disorders may be overlooked. Be sure that shoes are large enough so that they do not exert pressure; do not cut corns—consult physician; if corns are cut, sterilize scissors, and if there is any sign of blood, treat the part as an open wound.

The patient who is *unsteady* is often dizzy and falls easily; he bumps into tables, chairs, and doorways and trips over door sills and rugs. Place furniture with these accidents in mind. Assist the patient up and down stairs, getting in and out of chairs, and to and from the toilet. If the patient resents help, do not give unless necessary, but be alert to needs and possible accidents; if the patient needs assistance, do not wait until he asks for it.

Be aware of *fragility of bones* in this type of patient. Bones break easily and do not heal readily; be sure to report any fall, and examine carefully for injury.

The *poor condition of the skin* causes it to bruise easily, and the patient is susceptible to infection. A bruise or a cut that ordinarily would not require much attention should be given special attention and watched closely.

When *incontinence* exists, toilet regularly and frequently; when dribbling is present, do everything possible to keep dry by washing parts frequently and powdering. Appreciate that incontinence in a patient who has not been incontinent is a serious symptom (a suspicious sign of spinal-cord involvement); report and investigate closely—be sure the condition is incontinence and not overflow or just plain neglect.

Watch for *retention of urine*, also for signs of cystitis and pyelitis.

Many patients, especially at the beginning of hospitalization, have a tremendous *appetite*; help control this through the amount served and, if need be, feed in order to control speed in eating; consult physician; watch weight.

Give special attention to oral hygiene—the back of the throat as well as the mouth, and appreciate responsibilities with regard

to accidents and accident hazards. Watch for the following:

1. Suicide.
2. Choking at meals.
3. Gastrointestinal upsets.
4. Beginning infection.
5. Distended bladder and impacted rectum.
6. Pains and aches.
7. Collapse.
8. Bedsores. These may develop in a matter of hours with bed patients and patients with spinal cord involvement.
9. Signs of spinal cord involvement: incontinence of urine and feces; intense pain—feet, legs, abdomen; enlarged, relaxed joints (Charcot)—knee is most common; swaying when eyes are shut (Romberg sign—patient sways and loses balance when he stands with his heels and toes together and keeps eyes closed); and ataxic gait—unsteady, slapping movement of entire foot. Notice whether the patient sways when he shuts his eyes to wash his face—occasionally a patient falls at such a time; be sure to report either symptom.

When the patient is under treatment, the following nursing points should be observed:

1. Malaria. Help the patient to conserve energy.
2. Abscess. Be alert to beginning signs and report at once.
3. Extravenous injection. Physician will prescribe (sloughing can be prevented by the immediate continuous application of a cold wet towel).
4. Toxic symptom of vomiting. Know exact condition; the patient may not report such a serious symptom or may report it to get out of taking treatment.
5. Arsenicals. Watch closely for visual symptoms (mist or "sparkles" before the eyes), especially after the first few injections and a few hours after injection; skin eruption; and jaundice (acute toxic hepatitis).

Meningovascular Type (Cerebral Syphilis). Condition.—In this type the meninges and blood vessels (the framework) of the brain are affected. This is a milder condition than the meningo-encephalitic type.

Occurrence.—The onset of this condition occurs within a couple of years following initial infection of syphilis.

Prognosis.—With adequate treatment the prognosis is favorable.

Symptoms.—This condition may exist without evident clinical symptoms. Symptoms are related mostly to physical and neurological findings and depend on the location of the greatest amount of infection and the location and size of the blood vessels involved. Mental symptoms consist chiefly in confusion; the clinical picture may resemble meningoencephalitis, but the patient will respond quickly to treatment. Among symptoms frequently observed are headache, nausea, and vomiting. Evidence of meningeal involvement (syphilitic meningitis) may be present, including symptoms of injury to the cranial nerves—disturbances of vision, particularly diplopia, dropping (ptosis) of one lid, facial weakness, tinnitus, deafness; stiff neck; and Kernig's sign (when the thigh is flexed at the hip and the leg is extended at the knee, there are pain and resistance). There may be evidence of vascular involvement (inflammation of vessel walls; the vessel tube narrows and the inner lining is destroyed)—symptoms of thrombosis of cerebral blood vessels (like those of thrombosis in arteriosclerosis) or symptoms of stroke (comes on gradually).

Treatment.—The purpose of treatment is to relieve symptoms and to prevent the development of complications, particularly the meningoencephalitic type. The danger to be avoided is cardiovascular disorders. The methods of treatment used are the following: administration of heavy metals (chiefly iodides, mercury, and bismuth) and arsenicals—arsphenamine, neoarsphenamine, silver arsphenamine, mapharsen, tryparsamide (chiefly the first two); fever therapy (not used until after treatment by heavy metals or arsenicals, use depends upon physical condition of the patient); and penicillin (final value not yet established). If arteriosclerosis is present, the treatment is usually modified. The principal therapy is the use of heavy metals, chiefly bismuth; if arsenicals are used, the dose is small.

Nursing Care.—Specific orders meet most nursing problems. Review material on nursing care of meningoencephalitic type; if heavy metals are used, watch for signs of toxicity: with iodides—rash, gastrointestinal upsets; with mercury—blue line on gums, bad breath, salivation, loosening of the teeth; with arsenicals—skin eruption, visual disturbances, jaundice.

PSYCHOSES WITH EPIDEMIC ENCEPHALITIS

Condition.—This is a virus infection of the brain (cerebrum).

Symptoms. The symptoms are divided into acute and residual.

The acute stage is of short duration; symptoms are often not recognized. Of the following symptoms not all may appear, and there is a characteristic shift of symptoms from time to time. The outstanding symptom is lethargy, sleepiness, or stupor which lasts for days or months; this particular symptom gives rise to the names "sleeping sickness" and "lethargic encephalitis." Additional symptoms of the acute stage are oculomotor disturbances—double vision (diplopia), sensitivity to light (photophobia), impaired vision, strabismus, nystagmus; headache; tinnitus; impairment of speech; impairment of hearing; general muscular weakness, particularly legs; hiccup; fever; tremors, twitching, and seizures. Mental manifestations are confusion, disorientation, memory defect, hallucinations, *flexibilitas cerea* (as in catatonic schizophrenia), and delirium in rare cases.

The residual symptoms appear several months or years after the acute condition and differ in children and in adults. In children the following behavior disorders are pronounced: temper tantrums; cruel, assaultive, mutilative tendencies. In general the behavior disorders are of a restless and aggressive kind. The residual picture in adults is Parkinson's syndrome: muscular rigidity; drooling of saliva from the mouth; characteristic mask-like expression; speech disturbance; propulsive gait—back curved, head forward, body rigid; fatigue, lethargy; physical complaints; sleep disturbances—almost any kind, inverted sleep rhythm being the most common; involuntary movements—tremor, ties, choreiform movements; respiratory disturbances; mental symptoms—irritability; moroseness; inability to concentrate; lack of interest (because of which intellectual capacity may seem impaired); specific reactions of elation, depression, affective indifference, anxiety, emotional instability, depression being the most common. Sometimes there are outbursts of activity during which crimes are committed.

Treatment.—With children retraining begins immediately following or during convalescence from the acute stage. The better aspects of previous training seem lost—the child uses bad language, has temper tantrums, defies authority. Punishment makes the

condition worse, but the child must not be spoiled. The day should be filled with interesting, wholesome activities.

For adults the program of treatment is as follows: Relaxation is encouraged through massage, hydrotherapy, and sedatives—barbiturates are not given as they increase muscular rigidity. Muscular rigidity is reduced by drugs such as hyoscine hydrobromide, Bulgarian belladonna, and tincture of stramonium. Salivation is prevented with atropine. Fatigue and lethargy are combated by amphetamine sulfate or benzedrine sulfate; there is a disadvantage in causing insomnia. Occupation is provided, but with extreme care because of the physical handicap. Fever therapy is sometimes used. Physical therapy and muscle reeducation are intensive.

Nursing Care.—Outstanding points in nursing care may be summarized as follows:

During the acute stage *isolate* the patient; use technique for acute infectious diseases. The patient is not seen on the psychiatric ward at this time.

Give special attention to *oral hygiene*—cleanliness of mouth and throat; give particular care to the disposal of nose and throat discharges, as the disease is thought to be spread by this means.

If the patient is getting *drugs* of the belladonna group, watch for dryness of mouth, disturbance of vision (dilated pupil, paralysis of muscles of accommodation), retention of urine or feces.

In regard to the *psychiatric aspects* of nursing care, apply principles used in the care of primary personality disorders; appreciate that the patient is easily influenced by general atmosphere. As the patient is easily irritated, avoid altercations; Do not hurry the patient; allow sufficient time for any particular activity. As the patient is easily discouraged in feeding himself, encourage his effort, give sufficient time, provide privacy without too much evidence of the reason, and appreciate that solids are easier to manage. Realize that the patient thinks clearly even though his expressionless face, lack of interest, and delayed reactions indicate the contrary. Watch for suicide.

ALCOHOLIC PSYCHOSES

Primary Problem. In alcoholic psychoses the immediate problem relates to alcoholism, but the primary problem is presented by the underlying personality of the chronic drinker.

Principal Types.—The principal types of alcoholic psychoses seen on psychiatric wards are delirium tremens, Korsakoff's psychosis, and alcoholic hallucinosis.

Delirium Tremens. *Condition.*—This is an acute alcoholic state. The condition arises in the course of chronic alcoholism, usually after a period of heavy drinking with little or no food.

Occurrence.—Delirium tremens is the most common form of alcoholic psychosis. The duration is 3 to 6 days with a long period of convalescence; recovery begins with a prolonged sleep of 24 to 36 hours.

Prognosis. Of patients with this psychosis 5 to 15 per cent die.

Symptoms.—In the prepsychotic period the symptoms are restlessness, moroseness, nightmares, mild hallucinations, skin sensations such as itching.

In the psychotitic period the outstanding symptoms are active delirium—confusion, disorientation, great motor unrest; marked tremor, especially in the face (tongue), hand (fingers); state of fear. Additional symptoms are: illusions; hallucinations, especially vivid, terrifying hallucinations of pink elephants, rats, snakes; fever; increased pulse rate; picking at bedclothes (carphology); sometimes convulsions.

In the postpsychotic period there is amnesia for the acute period.

Treatment.—This consists chiefly in rest and symptomatic treatment, specifically bed rest; protection; high-calorie, high-vitamin diet with additional vitamins, particularly vitamin B₁.

Sedatives are given as needed for rest, sleep, and control of excitement. Vitamin B is used for sedative effect (50 mg. intravenously daily for 3 or 4 successive days); chloral hydrate, paraldehyde, and hyoscine for maniacal excitement; and hot packs and continuous baths as mental condition permits.

Cerebrospinal fluid is reduced by spinal puncture, hypertonic solution (dextrose, saline, magnesium sulfate), and by limiting fluid intake (1,000 cc. in 24 hours).

Stimulation—heat, strong coffee, sodium benzoate, strychnine sulfate—is given for signs of exhaustion.

Nursing Care.—In regard to *psychiatric aspects*, appreciate that the patient is extremely sensitive to general atmosphere—never scold, threaten, or become irritated; never argue. Disregard the patient's incorrect ideas; any attempt to change them gives you a feeling of helplessness, inadequacy, and defeat.

When the patient is suffering from *delirium*, protect him against injury or suicide; give constant supervision during delirious period.

For the patient in a *state of fear* provide a sedative environment through the general ward atmosphere and by removing, as much as possible, any source of stimulation. Reduce noise, the number of people, the articles of equipment; do not have anything around that is not necessary, such as flowers. Remove exciting colors, such as red furnishings or a red bathrobe. Appreciate that moving objects excite. Isolate the patient in a room apart from other rooms—choose one with the least decoration, and the fewest windows, doorways, and jogs in the wall; remove the furniture; do not darken the room unless evidently beneficial, as shadows increase misinterpretations, suspicions, and fears.

Do everything possible to prevent *restlessness* by providing relaxation and sleep.

Never attempt to straighten out through words the incorrect ideas of the patient with *illusions* and *hallucinations*. His faith and assurance will come from the general ward atmosphere and from your own attitude and behavior. Protect the patient in his effort to crawl or run away from terrifying hallucinations.

Discuss the patient's *diet* with the physician. The patient probably needs extra nourishment; if permissible, give milk at frequent intervals.

Know the physician's wish in the matter of *fluids*. The patient's condition directs whether fluids are to be forced or restricted (forced, to reduce toxic effect and combat dehydration; restricted when there are signs of edema of the brain).

The *mouth* is foul; give special attention to oral hygiene.

Attention to *elimination* is very important, as this reduces the toxic effect. Give particular attention to bathing and to bladder and bowel elimination; provide toilet facilities at regular intervals; watch for distended bladder, constipation and impacted rectum.

Common *complications* are heart failure (watch pulse), bronchopneumonia (watch pulse and respiration), and acute infections.

Keep the patient from doing too much during convalescence. He seems so well, as compared with his appearance during the period of excitement, that one is apt to be fooled regarding his actual state of health.

Korsakoff's Psychosis (Alcoholic Korsakoff's Syndrome). *Condition.*—This is an organic brain condition usually associated with peripheral neuritis. The condition is seen frequently in relation to chronic alcoholism; however, the psychotic symptoms are not specific for alcoholism. The same symptoms are observed with debilitating conditions such as typhoid fever, pernicious vomiting of pregnancy, in senility, and as a residual of head injury.

Duration.—When the psychosis is due to alcoholism it lasts several months.

Prognosis.—The prognosis is not favorable as to complete recovery; there is usually evidence of brain damage. Frequently after the acute condition clears up, there remains some change in the personality, especially regarding emotional control and ethical behavior, as well as impairment of intellectual capacity, particularly memory.

Symptoms.—Early symptoms are tremor, perspiration, and tachycardia.

Outstanding symptoms of the psychosis are memory defect (chiefly for recent events, faulty retention); confabulation (compensation for memory defect); disorientation (space, time); amnesia. This condition may begin with a delirium not unlike delirium tremens; the symptoms, however, persist. The mental reaction after the acute stage has subsided is usually mild elation.

Physical symptoms associated with polyneuritis are tingling sensation in the extremities, chiefly the lower extremities; pain; loss of sensation; weakness (wrist, foot drop); paralysis. The presence of polyneuritis denotes a vitamin B deficiency—usually people do not eat properly during alcoholic sprees; also, alcohol seems to utilize vitamin B in the body.

Treatment.—Treatment consists in the withdrawal of alcohol; bed rest during the acute stage; analgesics; and high-caloric diet including vitamin administration.

Nursing Care.—Psychiatric aspects of care include the following: Watch for suicide; appreciate the significance of nursing care in the symptoms of restlessness, difficulty in concentrating, irritability, anxiety, memory defect, and fatigue upon slight exertion.

When there is pain and sensitivity to pressure, rubbing, even bathing, may have to be eliminated or reduced to a minimum during the acute stage; use methods to prevent pressure—pillows,

pads, supports, cradles; support feet and hands to prevent foot and wrist drop. The physician will give specific directions if reeducation in the use of muscles and memory is to be attempted.

Acute Hallucinosis. *Condition.*—This is an acute alcoholic mental state; the condition arises in the course of chronic alcoholism, usually during a period of heavy drinking.

Duration.—The onset is sudden and the condition lasts from 1 week to 2 months.

Prognosis.—Prognosis is favorable for the acute episode; remissions are frequent.

Symptoms.—The outstanding symptoms are hallucinations (mainly auditory and of a threatening nature); delusions of persecution (based on hallucinations); and state of fear (based on hallucinations). There is no loss of consciousness; contact with the environment remains clear.

Treatment.—Treatment consists in withdrawal of alcohol, rest, and protection; sometimes spinal fluid is removed to reduce pressure.

Nursing Care.—Psychiatric aspects include watching for escape, suicide, and aggressive, assaultive behavior.

Be sure to know the physician's wish regarding fluids; pay special attention to elimination.

PSYCHOSES DUE TO A DRUG OR OTHER EXOGENOUS POISONS

The disorders in this group are the psychotic reactions occasioned by a metal, a gas, opium or a derivative, or other drugs. The conditions are not identical, but there is a similarity in the clinical picture.

Symptoms.—Symptoms are as follows: Premonitory—headache, dizziness, fatigue, irritability, gastrointestinal disturbances; acute—confusion, delirium; residual—intellectual and emotional defect.

Treatment.—The treatment consists in removal of the toxic factor; eliminative procedures; transfusion (hemoglobin below 50 per cent); supportive measures; continued hospitalization if there is permanent brain damage.

Nursing Care.—The nursing care follows treatment; during delirium, protect constantly and reduce state of fear; pay special attention to elimination.

PSYCHOSES DUE TO TRAUMA (TRAUMATIC PSYCHOSES)

The psychoses due to trauma are those in which the psychotic reactions are brought about by injury to the head or brain. Not all head injuries cause mental disturbances.

Classification.—The classification of mental disorders following head injury is not uniform. Conditions are frequently viewed as acute or subacute, chronic or mixed type; and the personality changes are considered as mild (fatigue, lack of concentration, and emotional instability) and severe (delusions, hallucinations, asocial and antisocial behavior). The specific conditions discussed here are delirium due to trauma and personality disorders due to trauma.

Delirium Due to Trauma. *Occurrence.*—This condition arises immediately following a head injury.

Symptoms.—Symptoms are confusion, disorientation, unconsciousness, symptoms of shock, sometimes projectile vomiting or seizures. If there is damage to the brain and blood vessels, the following symptoms may appear: stiff neck, stupor, or paralysis of one side.

Treatment.—The treatment is symptomatic and includes combating shock.

Nursing Care.—The management of *delirium* is the principal psychiatric aspect. Never leave the patient alone; protect against injury. If the patient is moving about and trying to get out of bed, do not place the bed away from the wall; furthermore, it may be necessary to use side boards. Activity is usually increased the second or third day following injury. Do not talk about the patient or his condition while in his presence. Reduce the state of fear, chiefly through a sedative atmosphere.

As the patient returns to consciousness, make additional effort to reduce fear; in event of illusions, remove offending articles if possible; avoid fatigue; reduce noise, conversation, and number of people.

Turn the *bed* so that the foot is at the usual head; unless the patient is trying to get out of bed, place the bed out from the wall far enough so that you can walk between the bed and the wall. This simplifies treatment and care problems. If the patient is profoundly unconscious, it is simpler to put the patient in bed with his head at the foot of the bed; however, when consciousness

begins to return, appreciate that such a position may add to the patient's confusion and state of fear.

As to the *position of the patient*, the head is placed on a level with the body unless otherwise ordered and turned to one side to keep the tongue from dropping back into the throat and to help keep mucus out of the throat. The position of the head depends upon the pulse and the amount of fluid in the chest; the physician will give definite orders.

Take the *temperature* rectally (by mouth is dangerous, by axilla inaccurate unless careful technique is used—dry part, place thermometer correctly, hold in place). Take the temperature every hour and record until the patient is conscious for 12 hours with record fairly steady. If the temperature-control center is damaged, hyperthermia may result; if temperature is on the increase, keep physician informed, as treatment to check rising temperature must be started early.

Take the *pulse* every 15 minutes, and record until patient is conscious; report a pulse of 60 or below.

Count *respiration* along with the pulse every 15 minutes, and record. If there is breathing difficulty, keep the patient's head to one side, see that the tongue has not fallen back into the throat, turn the patient on one side, flex the upper knee, support with pillows at the back. If fluid collects in the throat, turn the patient every 3 or 4 hours. The physician may order that the head be lower than the body; suction apparatus may be needed to keep air passages clear.

Take the *blood pressure* every $\frac{1}{2}$ hour, and record; report a systolic pressure below 100.

In regard to *nourishment* and *fluids*, these may have to be administered by intravenous injection, hypodermoclysis, or tube feeding; when nourishment can be given by mouth, it should be light and frequent. Watch for choking. When fluids can be taken by mouth, obtain a specific order regarding the total amount allowed in 24 hours; keep a record of fluid intake and output.

Have the following *stimulants* available: adrenalin, caffeine, sodium benzoate, coramine.

If *sedatives* are used, appreciate that nursing responsibilities are increased, for symptoms will be masked.

If *surgery* is used, keep the patient quiet; immobilize the head with sandbags; sometimes the head is put in a cast. Handle the

patient as little as possible; obtain definite orders in regard to turning—for the first few days the patient may be dealt with as for eye or orthopedic surgery; if the patient is not turned, be especially careful to keep the bedclothes dry and smooth. Dressings are not changed as often as other surgical dressings. If the patient is receiving codeine (for pain), report respiration below 14 a minute.

Watch for the following *important symptoms*:

1. Increased blood pressure and slower pulse—report immediately (evidence of increased intracranial pressure).
2. Bleeding from ear, nose, or mouth.
3. Clear fluid from nose or ear (may be spinal fluid).
4. Weakness or paralysis of face, arm, or leg. When the patient moves, notice any repeated absence of movement in a part.
5. Twitching of facial muscles or convulsion. If there is a convulsion, notice the way in which it starts and the part first to jerk or twitch (this may indicate the location of brain damage).
6. Fluid and mucus in lungs and throat. The patient may have to be turned frequently to prevent the accumulation of fluid in one place; ask physician.
7. Any difference in the size of pupils. One pupil dilated may indicate hemorrhage on that side of the brain.

Give *special attention* to the following points:

1. Open wound. Watch for bleeding, prevent infection.
2. Bladder and bowels. If the patient is incontinent, wash and dry every time the patient is turned; keep bowels open.
3. State of consciousness. Know whether unconsciousness is profound; recognize appearance of stupor.
4. Oral hygiene. Keep mouth clean, lubricate lips with glycerine.
5. Dry secretions. Moisten before removing.
6. Bedsores. Watch for and protect against; they may develop quickly.
7. Warmth. Be sure body and feet are sufficiently warm; be especially careful in using a hot-water bottle to have the temperature of the water not over 118° F.
8. Watch especially for symptoms of increased intracranial pressure, beginning hyperthermia, noises in the chest (presence of fluid), signs of paralysis, and twitching or jerking (seizures).

Personality Disorders Due to Trauma. *Occurrence.*—This condition is delayed; the symptoms develop gradually and appear days, weeks, or months after the head injury.

Symptoms.—The symptoms of change in personality are irritability (easily fatigued), marked emotional instability, temper outbursts, decrease in interests, judgment and memory defect, fabrication, inability to work or play, feeling states against own family. Possible changes in the physical field are aphasia and convulsions.

Treatment.—The treatment is symptomatic.

Nursing Care.—The nursing care follows treatment. In all interpersonal relationships, consider emotional and intellectual limitations. If the condition is diagnosed as posttraumatic neurosis, nursing care corresponds to that described under the heading "Unwholesome Attitudes."

Occasionally a patient is in the hospital for observation in order that it can be determined whether a known head injury is the direct cause of a mild personality change—headache, easy fatigue with irritability, or emotional instability. Usually the reason for observation has compensatory or legal aspects. In such cases be particularly objective, honest, and accurate in reporting and recording symptoms; watch especially for signs of encephalopathy (inability to concentrate, particularly on productive work), memory defect, judgment defect, fabrication, aphasia, tremor, twitching, jerking, muscle weakness, and convulsion.

PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS

Condition.—In psychoses with cerebral arteriosclerosis, the cause is an organic degeneration. Because of hardening of the arteries of the body and brain, there is interference with the cerebral circulation, which results in sluggish circulation, anemia, and cerebral destruction.

Occurrence.—This condition occurs in middle-aged and elderly people of fifty to sixty-five years. The onset may be gradual or introduced suddenly by an apoplectic stroke or an aphasic attack. *Any change in the behavior of a person over fifty requires medical attention.*

Prophylaxis.—Prophylaxis is a matter of hygiene for old age. Some outstanding points for persons of this age are: Reduce men-

tal and physical activity both as to amount and kind; take mild exercise in the open air; avoid emotional upsets; provide a moderate, small diet—this is more important than kind—low on salt and protein; in bathing, have the water at a neutral temperature; rest should be sufficient to meet the body needs and may require short rest periods during the day; life should be regulated and routinized with a simple regime; there should be suitable recreation; interests and hobbies that are satisfactory to a less strenuous life should be developed.

Prognosis.—The prognosis is unfavorable. The condition is progressive but not steadily progressive; there may be remissions.

Symptoms.—The change in the personality and the lack of insight into the condition depend upon the amount of circulatory disturbance and cerebral destruction.

Early symptoms are fatigability, irritability, lessening of initiative, impairment in alertness and concentration, tendency to depression. In the early stage there is recognition (not present in senile dementia) of failing mental function.

Later symptoms are difficulty in sustained mental operations; confusion; loss of memory; lability of mood; general impairment of intellectual functions. As the condition progresses, there are outbursts of excitement; episodes of violence; delusions—persecution, ideas of ruin, body changes; unsteady gait (however, the patient steps out with a firm tread, contrary to those with senile dementia who take little steps and shuffle along); carelessness about personal appearance.

The outstanding characteristic of psychoses with cerebral arteriosclerosis is remissions (fluctuations regarding orientation and capacity to recall); these become less as the condition progresses.

Complications are sudden disability, paryses. Premonitory symptoms, if present, are headache; dizziness, especially with change in posture; tinnitus.

These complications occur frequently at night or after a heavy meal; the lesion is usually an area of softening rather than hemorrhage. Brain hemorrhage, which may occur, usually takes place when the patient is excited, working hard, or straining at the toilet.

Treatment and Care. In general the treatment and care center around (1) mode of living—regulated, simple regime, interesting activities (to prevent progression of condition); (2) sedation for

confused and excited episodes; and (3) protection against judgment defect (sexual misdemeanors, giving away articles of worth).

For *bathing*, the temperature of the water is very important—use neutral temperature to prevent circulatory changes and shock; hot or cold baths are prohibited. A sponge bath is better than a tub bath or shower. If the patient takes a tub bath, assist him in and out of the tub each time (do not take a chance, the patient is apt to fall).

Give special attention to the *bed*. These patients fall out of bed. If possible have low beds; also, have the patient where he does not have to climb stairs—a first floor with a ramp to the outdoors is the most desirable location. If the patient is bedridden, keep head and chest elevated; watch for bedsores; appreciate that feeding is a slow process; give fruit juice to help prevent constipation; realize that paralyzed parts become spastic, do not pull (painful).

Give *special attention* to the following:

1. Falls. This type of patient falls easily and breaks bones; if the patient falls, he will probably say he tripped over a rug or some other object; look for symptoms of stroke before looking for the rug; do not have loose rugs or rugs rolled up for the night lying around.
2. Dehydration.
3. Retention of urine.
4. Constipation and fecal impaction.
5. Confused episodes.
6. Symptoms of cerebral hemorrhage—sudden coma, rapid pulse, stertorous breathing, paralysis of an arm or leg.
7. Symptoms of heart or kidney disease.
8. Symptoms of diabetes (great thirst).

Psychiatric aspects of nursing care include the following: Recognize and appreciate the significance of nursing care when the following symptoms appear: emotional instability, irritability, inability to think quickly and accurately, reduced comprehension, obstinacy, dulling of sensory receptors. Protect from mental and physical strain; avoid emotional upsets; do not expect more than the patient has to give and appreciate that the patient's capacities are greater at some times than others; realize that faulty perception means that the patient will not be aware of the

presence of crumbs, wrinkles, pins, wet clothing or bedding, a hot-water bottle that is too hot, or contact with a hot radiator.

When there are *outbursts of excitement* it is usually easy to learn what upsets the patient; if possible rectify or avoid in the future. It is not difficult to sense immediate reactions; be alert to what is about to take place. Violence and excited episodes are often the forerunners of a complication or a change in the condition.

If the patient suffers from *insomnia*, see that he is sufficiently warm; give him a warm drink; read aloud in a monotonous voice; be sure the bed is comfortable—smooth and dry.

Evaluate the *personality type* in health and deal with the patient accordingly. Regardless of the behavior, a dominating personality will resent being bossed or treated like a child; a “clinging vine” will want to continue to lean on someone else.

When *speech disturbances* occur, particularly when the patient cannot say the right words, remember that he understands the spoken word; help him to conserve words; show understanding—do not complete the sentence but respond to what you know he wants to say.

These people like *company*. Take them to the hospital social affairs; even if they cannot take part, they enjoy watching what goes on.

There are practical differences in the nursing care of the patient with a psychosis associated with arteriosclerosis as compared with a person suffering from senile psychosis. The arteriosclerotic person is less wearing. He is more irritable, temper outbursts are more violent, and there is greater destructiveness; but there is something tangible in the way of personality with which to deal.

The patient will be angry, very angry, and then again sweet-tempered; however, *you are able to understand why*. If it is possible to do something about a trying situation, the patient will express thanks or praise. Immediate reactions can be sensed and unhappiness and unfortunate happenings prevented.

The main point is that the arteriosclerotic patient is a virile individual. Almost until he dies, he has vigor, life, fight; his course in illness is stormy; even his death has a decisive quality—stroke, pneumonia.

The arteriosclerotic patient demands every bit of energy you have, but there are tangible rewards. There is a warmth, a responsiveness not found in the patient suffering from a senile psychosis.

PSYCHOSES DUE TO CONVULSIVE DISORDER (EPILEPSY)

While there are quite a few patients of this type in the hospitals for the mentally ill, the proportion is small. The specific conditions considered here are epileptic deterioration and epileptic states. The word "epilepsy" is falling into disuse, as the word means "seizure" and refers to a symptom rather than a disease.

Primary Physical Condition. -In this group the disorders considered are those that show psychotic disturbances associated with idiopathic epilepsy, which is a condition characterized by periodic seizures that are the primary symptom of illness. There is a known disturbance in the brain rhythm (cerebral dysrhythmia); the recording by the electroencephalograph shows a reduction in the frequency of brain waves from the normal 10 to 11 per second to about three-tenths per second. (In Jacksonian epilepsy the seizures are due to a known focus of irritation in some part of the cerebral motor area; during a seizure, a group of muscles are involved—not the entire musculature—and consciousness is usually not lost.)

When school nurses find odd behavior in children—rage, temper tantrums, dizziness, forgetfulness—they should look for a history of "spells" and, if positive, refer the child for medical attention.

Seizure. The outstanding characteristics of seizure in this type of patient are jerking and twitching involving all skeletal muscles and complete unconsciousness. The seizures are of two kinds—grand mal, or major attack; and petit mal, or minor attack. For description of seizure and nursing care, see the discussion of special problems under the heading "Seizures," page 204.

Epileptic Deterioration (Dementia). *Symptoms.* The outstanding symptoms are apathy; irritability; mental enfeeblement—dullness, slowness in thinking, impairment of memory, slow monotonous speech.

Treatment and Care.—With modern treatment given early this condition should be greatly improved; after dementia is established, the treatment and care are custodial and similar to that for patients with mental deficiency.

Epileptic Clouded States. *Symptoms.*—Mental upsets occur before or after a seizure, or as an equivalent to a seizure; these consist of dazed reactions with deep confusion, anxiety, fears, ecstatic moods, religious exaltation, violent outbursts, and destructive, assaultive behavior. During clouded states the person may carry

on some activity, such as mowing a lawn or burning a house, and be wholly unaware of what he is doing.

An *epileptic fugue* is postseizure behavior; the person may get up and run away, if he can; he may run for miles and then not know where he is, how he got there, or how to get back.

In an *epileptic furor*, the person is excited and irrational, has a violent outburst directed at property or people, with an amnesia for the attack; the behavior may follow a seizure or appear as an equivalent. The behavior is dangerous.

Treatment.—Treatment consists of general hygienic measures—routine in living; hobbies and interests so that the patient is not allowed to stand around waiting for seizures; vigorous exercise, especially out of doors (walking, badminton). The purpose of exercise is to increase the accumulation of acid in the blood—some consider that this reduces the number of seizures. In outdoor activities the patient mixes with others and leads a more normal life. Saline earharties are helpful. Attention is given to the amount of food taken, as there is a tendency to overeat; a ketogenic diet—high in fat, low in protein and carbohydrate, in order to produce acidosis—is used, mostly with children.

Drugs are given to reduce the number and severity of seizures: bromides, usually sodium bromides; barbiturates, particularly phenobarbital (luminal)—sometimes called the standard anti-convulsant; and sodium diphenyl hydantoinate (dilantin). In petit mal seizures, stimulating drugs such as caffeine, amphetamine sulfate, and Tridione are being used with the idea of increasing brain-wave frequency. An important part of treatment is the help that the physician gives the patient in learning to deal with his own problem.

Nursing Care.—Pay special attention to *personal hygiene*, particularly constipation.

This type of patient has great tolerance for *drugs*, but be aware of just what is taking place. With bromides watch for rash on the face, neck, or chest; with phenobarbital, drowsiness, irritability, or an increase in psychomotor activity. When dilantin is used, give special attention to the mouth and teeth—keep clean, brush teeth well, massage gums; report any unexpected change such as nausea, burning, dizziness, headache, fever, rash, overgrowth of gums. With the withdrawal of any drugs, watch for severe seizures.

In regard to the *diet*, moderation and regularity at meals are very important; if the ketogenic diet is used, send a specimen of urine to the laboratory once a week (acetone bodies in urine indicate acidity of blood); watch for any relationship between seizures and a certain food or coffee, tea, etc.

Know the physician's wish regarding *fluids*. Sometimes fluids are greatly restricted and the management of thirst becomes a difficult problem; keep the patient cool so that fluid is not lost through perspiration.

The patient's behavior just previous to a seizure is consistent so that it is possible to *predict seizures*—certain movements, quarrelsomeness, boisterousness. If such a connection becomes established, see that the patient is in a suitable place, have him remove false teeth, supervise him, and prevent others from seeing the seizure.

As to the psychiatric aspects of nursing care, help the patient to live as normal a life as possible and in quiet, comfortable surroundings; stimulate available goals; help him to mix with others; provide an atmosphere of hope and courage; create situations that give him a sense of being worth while; realize that the intelligence is not necessarily changed; appreciate that the frequency of seizures is increased by fatigue, excitement, emotional disturbances, irregularity in living, constipation, and sudden vigorous effort. Establish a routine for living—a definite program for rising, eating, all daily activities, and going to bed; realize the possibility of sexual indiscretions, homicidal attacks, and destructive and dangerous behavior. See that the patient is occupied, and provide opportunity to give expression to creative needs. Be alert to any planning of undesirable group activity; give special attention to possible escape, as the consequences may be dangerous to the patient and to others. Help the patient to meet many of his own responsibilities relating to treatment—the physician will give orders or suggestions. Watch for suicide.

SENILO PSYCHOSES

Condition.—Some mental change is characteristic of, and normal for, old age. Some of these outstanding changes are self-centering of interests, reminiscence, and difficulty in assimilation of new experiences so that there are forgetfulness of recent occurrences,

childish emotional reactions, irritability on slight provocation. Physically the person shows the signs of old age—wrinkled skin, reduced acuity of special senses, awkward, unsteady movements. In psychotic conditions there is an exaggeration of normal senile mental changes; clinical types are classified according to the predominance of certain groups of symptoms. These are the real mental disorders of old age.

Cause.—The cause is organic degeneration, specifically degenerative changes in the brain.

Occurrence.—The age of the person with senile psychoses is usually sixty-five or over.

Prognosis.—The prognosis is bad. The course is progressive, and there are no remissions.

Symptoms.—In this clinical type the outstanding symptoms are exaggeration of normal senile mental changes—loss of memory for recent events, defect of attention and concentration, misidentification of persons and places, and lack of appreciation of time. In addition there may be marked irritability or assaultiveness, erotic excitement, delusions, and finally, mere vegetative existence.

Among the outstanding symptoms of the *presbyophrenic type* are severe memory and retention defects and complete disorientation. At the same time there are preservation of mental alertness and attentiveness, and ability to grasp immediate impressions and conversation quite well. Forgetfulness leads to marked contradictions and repetitions; suggestibility and free fabrication are prominent symptoms. The general picture resembles Korsakoff's syndrome.

The outstanding symptoms of the *delirious and confused type* are deep confusion and a delirious condition. This condition is often precipitated by acute illness.

The outstanding symptoms of the *depressed and agitated types* are depression and persistent agitation. (The defect in memory and grasp of recent occurrences is different from involutional melancholia.)

The outstanding symptoms of the *paranoid types* are well-marked delusional trends (persecutory or expansive) and mental enfeeblement. Memory may be fairly well preserved.

Still another type, *Alzheimer's disease (presenile sclerosis)*, is a senile condition occurring at a comparatively early age, between thirty and fifty years. The outstanding symptom is progressive

mental deterioration. This resembles old age, but the intellectual deterioration is greater than the general symptoms of senility. Additional symptoms are aphasia or apraxia, restlessness, overactivity, and disorientation. The course is a rapid deterioration and death.

Treatment.—In general the treatment is to keep the person physically comfortable and pleased. Detailed treatment includes the establishment of a simple way of living with little strain on the individual, symptomatic treatment, consideration of physical and mental limitations, and association with people of his own age and condition.

Nursing Care.—Patients are usually segregated so that the environment can be adjusted to their needs. A program should be established for routine living—eating, bathing, elimination, and exercise. The total program should be as simple as possible; activities should be limited in amount at any one time. You are expected to understand and make allowances for childishness, forgetfulness, the general slowing up of mental and physical activities, the changes in sleep habits, and an inability to change established habits.

In order to *prevent accidents* pay attention to

1. Rugs. Do not have curled edges; do not roll up and leave where patient can trip over them; do not have scatter rugs.
2. Furniture. Place tables, rockers, etc., where there is the least danger of the patient bumping into corners; do not keep changing the location.
3. Bed. These patients fall out of bed; use of low beds reduces the number of fractures.
4. Floors. Do not have floors highly polished; do not allow patients to walk on wet floors; do not allow water to stand on floors.
5. Stairs. If possible eliminate the use of stairs; the first floor with a ramp is a desirable location; balconies are a fair substitute.
6. Baths. Give sponge baths altogether, in tub baths and showers there is a danger of slipping and there is also the danger of mild shock; if the patient may have a tub bath, help him to get in and out of the tub, and have a bath mat ready for him to step on.

7. Falls. Any fall for an old person is dangerous; report all falls and examine patient carefully; an apparently slight accident may mean a fracture and death; hip fractures are common.

The physical aspects of nursing care may be summarized as follows:

The *diet* should be simple and easily digested; milk and soft foods are excellent. Unless there are specific orders, the diet should consist of fruits, vegetables, milk, eggs, and creamed shredded meats. This type of patient likes sweets. The condition of the chewing apparatus enters into a consideration of diet. Regarding the time of eating, it may be wise to have patients eat fairly often, small amounts at a time; a bedtime snack is helpful for general comfort and for sleep. The heaviest meal should be eaten in the middle of the day; some hot food for the evening meal is beneficial.

Attention to *sleep* is important. This type of patient may want to sleep more, retire earlier, and get up earlier; sometimes, especially in the psychotic conditions, there is a reversal of sleep habits—a desire to sleep in the daytime and be awake and wander about at night. The patient should not be allowed to sleep at any time he desires just because he is sleepy; definite rest periods should be established in the morning and afternoon. Giving the patient a hot drink before he settles for sleep and making sure that the patient is sufficiently warm and the bed dry and smooth do wonders. If the patient awakens early, about 4:30 or 5 A.M., give a hot milk drink.

If possible use a low bed—this makes the patient feel more secure; protect the bed at night—push it against the wall and place a couple of chairs in front; use side boards if necessary; tell the patient why you are doing these things and then do not neglect him; if he moves about, be there immediately—he probably wants to go to the toilet. Watch for wandering about at night.

Establish a definite program of *elimination*. Sponge baths are best, given with as little fuss as possible. Make the procedure simple; be sure the room is sufficiently warm; do not leave any part of the body uncovered, as the patient chills easily. If the patient has urinary difficulties, toilet at regular intervals, including $\frac{1}{2}$ hour after meals; establish the interval according to the individual need. If he has difficulties at night, restrict fluid intake

during the latter part of the afternoon and evening. Pay particular attention to time for toileting; for example, if the patient urinates regularly about 2 A.M., a time for toileting is 1:30 A.M. If he is incontinent, wash regularly; keep clean and dry. Be alert to constipation and diarrhea; if diarrhea is present, watch for fecal impaction to follow.

Some *exercise* is necessary; it must be mild and in keeping with the physical capacity in general and at a particular time; outdoor exercise is preferable; a short walk, assisted, to a comfortable chair under a tree is a satisfactory type of exercise.

The *skin* is soft and thin, and there is a diminution of sensation. The skin is easily bruised, and the patient is easily burned with hot-water bottles and hot radiators. Keep the skin dry; use vegetable oils rather than alcohol for back rub. Do not rub too hard; it is not necessary, and the skin breaks easily.

The *bones* of this type of patient are brittle; they break easily and heal very slowly. Report all falls and examine closely for injury. A fall for an old person is a serious matter.

Give special attention to *oral hygiene*; keep the mouth clean and sweet. If the patient has false teeth, keep them clean; encourage their use, especially in the daytime.

Guard against *chilling*. Because of a loss of fatty tissue under the skin, patients are easily chilled. Have the temperature of the room 70° F. by day and 68° F. by night. Avoid drafts -shut the windows before the patient starts to get up in the morning, and shut them in time to have the room sufficiently warm when he begins to dress, or have a special dressing room. When the patient is in bed, keep the feet warm with socks; have long night clothes and enough blankets. Watch the weight of the blankets; have sufficient warmth underneath the patient. If the patient gets up at night, he probably wants to go to the toilet. Have bathrobe and slippers at hand. As soon as the patient begins to move, be at his side, put on the bathrobe and slippers, pull up the upper bedclothes so that the bed will not get chilled, and hold on to the patient while he goes to the toilet and returns to bed, then tuck him in warm and snug. If you do not assist the patient, he is apt to become confused, wander around, and be emotionally distressed.

There is a general *slowing up and awkwardness* in all activity. Do not hurry the patient, as this adds strain and confusion and

increases the fear of falling. Allow sufficient time for any particular activity; pay special attention to time allowed for eating; appreciate that the patient is slowest in the morning.

Watch for symptoms of complications: bronchitis (persistent cough); asthma; heart disease; cerebral hemorrhage (usually preceded by period of excitement); unconscious, one-sided paralysis.

Patients with senile psychoses are not put to bed until absolutely necessary, for the following reasons: psychological implication; difficulty in preventing bedsores and hypostatic pneumonia; weakening effect on voluntary muscles; adverse effect on vaso-motor tone; predisposition to thrombophlebitis of the extremities, pulmonary embolism, and collapse.

The psychiatric aspects of nursing care comprise the following:

The patient is *forgetful*. If there is anything he should do, he has to be told each time and given help each step of the way. He may turn on a water faucet and forget to turn it off, or start to get dressed but forget the order for articles of clothing and appear improperly or queerly dressed. He may start for the toilet but forget where it is. The patient may forget where he placed certain articles and accuse others of stealing.

Evaluate the patient's *behavior*. If he puts something in his mouth, very likely he is hungry; if he gets into bed with his clothes on, he is sleepy.

With regard to *speech difficulties*, let the patient talk and be tolerant toward his slowness and difficulty in articulation. Do not finish the sentences for him but try to grasp what he wants to say. Do not raise your voice as though he were deaf.

Many patients are careless about *appearance*—dress and toilet habits, often because no one cares enough to see that they are different. Dress them up for Sundays, have false teeth in place when they have visitors, fix the hair neatly, put a flower here or there. Assist and praise when praise can be given honestly. Show an interest in the patient; he will respond some—for a few minutes the face will show a glint of pleasure.

Many patients suffer from *loneliness*; they are discouraged and waiting for death. Like them (if not, try not to be with them), let them sense they are wanted, that they have friends, that you are a friend, and that they still have a place in the world.

In *conversation*, the patient will talk mostly about the past—what kind of house he lived in, where he went to school, who

taught him, his various first experiences skating, sleigh riding, calling on a girl, etc., and with little deviation. Before he is too deteriorated, he will tell over and over again about his great deeds as a young man, his wondrous accomplishments, his fine grades at school, his many love affairs. Try to enjoy these accounts. When the patient is low in spirits, mention one of these episodes.

Disregard *delusions*; never argue.

The patient's *hoarding* becomes a real problem, because his place gets cluttered so quickly. A general cleaning must be made at least once a week. If some small item is cherished, weigh the importance to the patient and the need before discarding; fortunately forgetfulness helps in these matters.

Many of the patient's *peculiarities* are due to intellectual defects. He may get out of bed and wander around when he had intended to go to the toilet; he may eat dessert before soup or skip pages in filling a scrapbook. He may want to wear a nightcap, carry around a piece of string, or have a box under the bed for trinkets—women love boxes under the bed. So far as possible let the patient have these pleasures. One of the real reasons for segregation is to prevent his way of living from interfering with people who want to live differently.

The patient will be very *irritable* at times, but the irritability will subside as deterioration progresses. Prevent unnecessary irritation; avoid arguments; be a companion, but do not "boss"; separate patients who irritate each other.

Appreciate that a period of *excitement* is possibly a forerunner of a physical change—collapse or stroke.

Be aware of *judgment defects*. The patient may give away articles of worth; may be indiscreet in sexual activities, especially with young people. These problems are serious in the community, but not particularly so on the ward.

Patients with senile psychoses are *afraid* of being left alone, especially at night. Stay near them and pass by the bed occasionally just to give assurance. Changes in established routine frighten the patient—let him stay on the same ward, have the same bed, the same place at the table, and the same place in which to put personal belongings; do not keep moving furniture about.

Provide *occupation*. Give the patient something to do to pass the time. Just to be in the midst of other people gives pleasure; to

sit under a tree is very much enjoyed. Some possible activities are music; games; simple puzzles; reading to the patient if he cannot read himself—material should be in keeping with mental capacity and presented in small amounts (cannot hold attention). Read stories that the patient liked years ago. If a woman patient wants to help with dusting, let her do so; however, realize that the product is not important—she will not accomplish much, but it will not matter if a particular piece of furniture is not dusted well until the patient is having a nap or is out to a meal.

In dealing with this type of patient, it is easy to forget the person. He may show the marks of having led an intellectual life—white face, soft hands; but no matter how great he was, it all seems lost. He may get angry and excited, be nasty, or refuse to eat; however, the behavior has a useless, futile quality, and doing things for him is not unlike stirring porridge.

For many nurses it is hard to retain interest in the care of patients with senile conditions. Usually when this type of patient is hospitalized, he no longer has the mental equipment with which to make adjustments, and nursing satisfactions are entirely within oneself—knowledge of a piece of work well done.

These people need a simple life without strain, physical comforts, understanding of their peculiarities, and the companionship of old people. They seem most pleased when cared for by kindly middle-aged women attendants.

REFERENCES

BOOKS¹

- BENNETT, A. E. and AVIS PURDY: "Psychiatric Nursing Technic," F. A. Davis Company, Philadelphia, 1940.
- BOND, EARL D.: "Post-encephalitic and Post-traumatic Behavior Disorders," in "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- CICERO (Translator, C. R. EDMONDS): "On Old Age (*De Senectute*)," David McKay Company, Philadelphia, 1896.
- COBB, STANLEY: "Personality as Affected by Lesions of the Brain," in "Personality and the Behavior Disorders," J. McV. Hunt, Editor, The Ronald Press Company, New York, 1944.
- COURVILLE, CYRIL B.: "Pathology of the Central Nervous System," Pacific Press Publishing Association, Mountain View, Calif., 1937.

¹ See list of textbooks for nurses on page 163.

For references on pharmacology, see Chapter VI.

- COWDRY, E., Editor: "The Problems of Aging," The Williams & Wilkins Company, Baltimore, 1939.
- EBAUGH, FRANKLIN G.: "The Toxic Reaction Types," in "Psychiatry for Practitioners," Henry A. Christian, Editor, Oxford University Press, New York, 1936.
- FULTON, J. F.: "Physiology of the Nervous System," 2nd ed., Oxford University Press, New York, 1943.
- GOTTEN, NICHOLAS and LETITIA WILSON: "Neurological Nursing," F. A. Davis Company, Philadelphia, 1945.
- GRINKER, ROY R.: "Neurology," 2nd ed., Charles C. Thomas, Publisher, Springfield, Ill., 1937.
- HAMBY, WALLACE B.: "The Hospital Care of Neurosurgical Patients," Charles C. Thomas, Publisher, Springfield, Ill., 1940.
- HOSKINS, R. G.: "Endocrinology: The Glands and Their Function," W. W. Norton & Company, Inc., New York, 1945.
- HUNT, J. McV., Editor: "Personality and the Behavior Disorders," The Ronald Press Company, New York, 1944.
- KAPLAN, OSCAR J., Editor: "Mental Disorders in Later Life," Stanford University Press, Stanford University, Calif., 1945.
- LAWTON, GEORGE: "New Goals for Old Age," Columbia University Press, New York, 1943.
- LENNOX, W. G.: "Science and Seizures: New Light on Epilepsy and Migraine," Harper & Brothers, New York, 1941.
- LENNOX, W. G.: "Seizure States," in "Personality and the Behavior Disorders," J. McV. Hunt, Editor, The Ronald Press Company, New York, 1944.
- MUNRO, DONALD: "Cranio-cerebral Injuries," Oxford University Press, New York, 1938.
- NEAL, JOSEPHINE B., *et al.*: "Encephalitis, A Clinical Study," Grune & Stratton, New York, 1942.
- PUTNAM, TRACY J.: "Convulsive Seizures," J. B. Lippincott Company, Philadelphia, 1943.
- RANSOM, STEPHEN W.: "The Anatomy of the Nervous System from the Stand-point of Development and Function," 7th ed. rev., W. B. Saunders Company, Philadelphia, 1943.
- SADOW, SUE: "Diets for Elderly Persons," Welfare Council of New York City, New York, 1937.
- SELIGER, ROBERT: "Alcoholics Are Sick People," Alcoholism Publications, Baltimore, 1945.
- SPIEGEL, E. A. and I. SOMMER: "Neurology of the Eye, Ear, Nose and Throat," Grune & Stratton, New York, 1944.
- STRECKER, EDWARD A., and FRANCIS T. CHAMBERS: "Alcohol—One Man's Meat," The Macmillan Company, New York, 1938.
- STRONG, OLIVER S. and A. ELWYN: "Human Neuroanatomy," The Williams & Wilkins Company, Baltimore, 1943. (320 illustrations.)
- THEWLIS, MALFORD W.: "The Care of the Aged (Geriatrics)," 3rd ed., The C. V. Mosby Company, St. Louis, 1941.

- WECHSLER, I. S.: "A Textbook of Clinical Neurology," 5th ed., W. B. Saunders Company, Philadelphia, 1943.
- WEIL, ARTHUR: "Textbook of Neuropathology," Grune & Stratton, New York, 1945.
- WEISENBURG, T. and K. E. McBRIDE: "Aphasia: A Clinical and Psychological Study," Commonwealth Fund, New York, 1935.
- WILSON, S. A. KINNIE, edited by A. N. BRUCE: "Neurology," 2 vols., The Williams & Wilkins Company, Baltimore, 1940.

See also six papers on "Mental Hygiene in Old Age," Family Welfare Association of America, New York, 1937.

ARTICLES

- ADLER, ALEXANDRA. "Two Different Types of Post-traumatic Neuroses," *The American Journal of Psychiatry*, September 1945, pp. 237-240.
- BARBARA, DOMINICK. "The Neurotic Character Structure of the Alcoholic Personality," *The Psychiatric Quarterly*, July 1945, pp. 503-515.
- BECKENSTEIN, N. and L. GOLD. "Problems of the Senile and Arteriosclerotic Mental Patient: Review of 200 Cases," *The Psychiatric Quarterly*, July 1945, pp. 398-411.
- BIXLER, ELIZABETH. "The Nurse and Neurological Problems," *The American Journal of Nursing*, May 1935, pp. 425-430.
- CALDWELL, W. ALEX and W. W. HARDWICK. "Vitamin Deficiency and the Psychoses," *The Journal of Mental Science*, January 1944, pp. 95-108.
- CLOW, HOLLIS E. "A Study of One Hundred Patients Suffering from Psychosis with Cerebro-arteriosclerosis," *The American Journal of Psychiatry*, July 1940, pp. 16-26.
- DAVIS, J. E. "Recreational Therapy for the Chronic Alcoholic," *The Psychiatric Quarterly*, July 1945, pp. 450-464.
- FRANK, LAWRENCE. "The Problems of the Alcoholic Personality," *The Quarterly Journal of Studies on Alcohol*, September 1944, pp. 242-244.
- GUTTMAN, E. "Psychiatric Aspects of Head Injury," *The Journal of Mental Science*, January 1944, pp. 328-350.
- HEMPHILL, R. E. "Endocrinology in Clinical Psychiatry," *The Journal of Mental Science*, January 1944, pp. 410-434.
- GAVIGAN, ARTHUR. "The Care of the Aged: Its Medical Aspects," *The American Journal of Nursing*, February 1939, pp. 145-149.
- GELBACH, SARAH. "Nursing Care of the Aged," *The American Journal of Nursing*, December 1943, pp. 1112-1114.
- JONES, RUTH E. "Alcoholic Episodes and Their Nursing Care," *The American Journal of Nursing*, 1937, pp. 231-237.
- LAWTON, G., et al. "Old Age and Aging," *The American Journal of Orthopsychiatry*, January 1940, pp. 27-29, 85-87.
- LAWTON, GEORGE. "Happiness in Old Age," *Mental Hygiene*, April 1943, pp. 231-237.

- LENNOX, W. G. "The Petit Mal Epilepsies, Their Treatment with Tridione," *The Journal of the American Medical Association*, December 15, 1945, pp. 1069-1074.
- LEVIN, MAX. "Dehirious Disorientation—The Law of the Unfamiliar Mistaken for the Familiar," *The Journal of Mental Science*, October 1945, pp. 447-453.
- Lewis, N. D. C. "Mental Hygiene of the Senior," *Mental Hygiene*, July 1940, pp. 434-444.
- MARSH, FORT L. "Stabilization Instead of Restraint in the Care of Elderly Patients," *The American Journal of Nursing*, November 1944, pp. 1049-1050.
- MASSERMAN, JULIUS H. "Neurosis and Alcohol," *The American Journal of Psychiatry*, November 1944, pp. 389-395.
- MAYER-GROSS, M. "Arteriosclerotic, Senile and Presenile Psychoses," *The Journal of Mental Science*, January 1944, pp. 316-327.
- MELIA, MARGUERITE R. "The Mental Rehabilitation of Patients with Spinal Cord Injuries," *The American Journal of Nursing*, May 1945, pp. 370-372.
- MEYER, A. "Neuropathology," *The Journal of Mental Science*, January 1944, pp. 102-230.
- MILLER, HELEN H. "Acute Psychosis Following Surgical Procedures," *The British Medical Journal*, March 18, 1939, pp. 558-559.
- MOORE, MERRILL. "Alcoholism: Some Contemporary Opinions," *The American Journal of Psychiatry*, May 1941, pp. 1455-1469.
- NEAL, JOSEPHINE. "Insanity," *The American Journal of Nursing*, June 1938, pp. 549-553.
- NEON, W. D. and E. L. HUTTON. "Neurosyphilis and Its Treatment," *The Journal of Mental Science*, January 1944, pp. 351-364.
- NONNEMAN, N. C. et al. "The Nursing Care of Patients with Brain Injuries," *The American Journal of Nursing*, April 1945, pp. 259-262.
- OVERHOLT, W. "Some Mental Problems of Aging and Their Management," *Medical Annals of the District of Columbia*, February 1941, pp. 49-56.
- OWEN, TROYON. "The Mental View of the Menopause," *The American Journal of Psychiatry*, May 1945, pp. 756-759.
- PALMER, H. D. et al. "Therapy of Involutional Melancholia," *The American Journal of Psychiatry*, March 1941, pp. 1080-1115.
- PALMER, EVERETT H. "The Care of the Aged—Its Nursing Aspects," *The American Journal of Nursing*, February 1939, pp. 149-155.
- PIKER, PHILIP D. and JESS A. COHN. "Comprehensive Management of Delirium Tremens," *The Journal of the American Medical Association*, January 30, 1937, pp. 345-349.
- POHL, ERIN. "Some Problems Arising from a Study of Mental Patients over the Age of Sixty Years," *The Journal of Mental Science*, April 1944, pp. 554-565.
- REISS, M. "Neuroleptic Relationship," *The Journal of Mental Science*, January 1944, pp. 100-126.
- SIMON, B. and S. H. KALFMAN. "The Psychiatric Problems of the Aged," *Diseases of the Nervous System*, February 1941, pp. 62-65.

SECONDARY PERSONALITY CHANGES

- STRECKER, E. A. "Chronic Alcoholism: A Psychological Survey," *The Quarterly Journal of Studies on Alcohol*, June 1941, pp. 12-17.
- URSE, VLADIMIR G. "Alcoholic Mental Disorders," *The American Journal of Nursing*, March 1937, pp. 225-231.
- VOEGTLIN, W. L. and F. LEMERE. "The Treatment of Alcoholic Addictive Diseases: A Review of the Literature," *The Quarterly Journal of Studies on Alcohol*, March 1942, pp. 717-803.
- WESTON, MARY L. "Devices to Simplify Neurological Nursing," *The American Journal of Nursing*, January 1945, pp. 22-24.

CHAPTER IX

THE USE OF ART, LITERATURE, AND MUSIC

ART

Application.—In hospitals for the mentally ill, art is used as another potential in dealing with the individual as a whole, along with environmental, occupational, recreational, social, and educational aspects of care (see Chapters III and VII). A study of works of art helps you to develop a fundamental nursing need, namely, the appreciation of subjective behavior.

The heart of psychiatric nursing—modifying moods and changing attitudes—concerns the patient's inner life, particularly his emotions and feeling states. For effective care you must be able to recognize feeling states, to estimate the extent of a specific feeling state, and to comprehend a feeling state that is moving toward a climax. The study of certain works of art can contribute to this end, as it will help you to recognize the significance of posture, gestures, and facial expression as manifestations of inner mental and emotional states.

For an example, study Fig. 9.

1. Look at the figure until you are *aware* of sadness, despair.
2. Determine what produces your apperception of sadness.
(Search for the answer in the hands, the eyes, the line of the lips, the bend of the head.)
3. Associate your inner experience with the effect that patients on the ward have on you. (Recall particularly those with an agitated depression.)

The following works are suggested for additional study.

"The Last Supper," Leonardo da Vinci. Examine a reproduction which shows the detail of the figures clearly (see book by Adolf Rosenberg listed in references). Study the physical evidence of emotional serenity in the central figure (Christ), particularly the calm resignation in the inclination of the

head. Examine the picture for reactions of the disciples to Christ's statement, "One of you . . . shall betray me." The figures of the disciples are stationary, but consider the work until you experience a sense of motion from the expressions of inner restlessness; then explore for finer points—shock, apprehension, fear, horror, and grief. Judas, the face in the



FIG. 9. Miniature. (*Walters Art Gallery, Baltimore.*)

shadow to Christ's right, shows little dismay, and his outward sign of inner agitation is seen chiefly in the position of his right arm and hand—upsetting the salteellar and clutching the moneybag. Pay special attention to the hands of all the figures.

"Laocoön Group" (marble, Metropolitan Museum of Art, New York). This group represents a father and two sons attacked by serpents. Reproductions may be found in books on Greek sculpture for the latter part of the first century B.C. Study this work for the expression of agony. Sense the physical and mental struggle of the father, notice the drawn brow and half-open mouth—the climax of emotion is not yet reached; recognize despair in the face and body of the son at

the father's right and the suggestion of relief from strain in the other son who appears about to escape.

"Despair" (marble), Auguste Rodin (City Art Museum, St. Louis, Missouri).

"The Repentant Peter," El Greco (Phillips Memorial Gallery, Washington, D. C.).

"The Agony in the Garden," Raphael Santi (Metropolitan Museum of Art, New York).

"The Sob," David Alfara-Siqueiros (Museum of Modern Art, New York).

"Tornado over Kansas," John Steuart Curry (Hackley Art Gallery, Muskegon, Michigan).

"The Angelus," Jean François Millet.

For lighter moods and attitudes, consider the following:

"Girl at Half-open Door," Rembrandt van Rijn (The Art Institute of Chicago).

"Man with Wine Glass," Velasquez (The Toledo Museum of Art).

"Merry Lute Player," Frans Hals.

A study of the self-portraits of Rembrandt and van Gogh has value, especially when the portraits are associated with the life of the particular artist at the time the portrait was made. To carry this method of study further, evaluate these works of art for similarities and differences.

LITERATURE

Application.—For a better understanding of the patient, selected literature is a fruitful instrument of education. For the most part the literature suggested for study in this section presents characters who illustrate behavior with abnormal and pathological aspects. The subject matter is really case-study material similar to patient histories.

The general idea in this type of study is to consider these characters as actual people and study their unsuccessful lives from a standpoint of personal potentials, failure to develop a specific aspect of their personalities, faulty integration, human problems and reactions to these problems, behavior trends, and universal aspects.

Clinical psychiatric diagnoses are not considered, although this approach is possible with many of the characters suggested; the study should, in fact, help you to refrain from viewing patients in terms of disease entities. Until psychiatry reaches the third and final stage as a science—the formulation of universal laws and principles—clinical diagnoses are not particularly important from a nursing point of view. A thorough understanding of fear or of emotional immaturity is more helpful than knowing the symptoms of psychoneurosis, anxiety state; or schizophrenic reaction, hebephrenic type, although the latter is important, too. The fundamental nursing need concerns the patient as a human being—his problems and how to deal with them, his suffering, and the timeless, ageless characteristics of behavior, even symptomatic behavior.

People and their problems comprise the field of interest for the novelist and the dramatist as well as the psychiatrist. In describing life these writers capture pictures of maladjustment. While the novelist and the dramatist are not interested in diagnosis or in the mechanisms of behavior from a scientific point of view, the better their writing the more recognizable are the behavior patterns and the forces responsible for these patterns.

Objectives.—As considered here, a study of literature should help you to understand the patient. It represents a shift in emphasis from technical to human aspects and should enlarge your information on human problems. It will enable you to perceive human suffering, to discern subtle human relationships, to develop acute observation regarding emotional states, and to see the universal aspects of the behavior of characters studied. A study of literature as outlined should help you to acquire specific knowledge of behavior, *e.g.*, to realize that the consideration of psychotic behavior is only one aspect of study; to gain insight into behavior symptoms, especially those respecting incipient, benign, and non-psychotic aspects; to see cause-and-effect relationships in behavior; and to increase your vocabulary concerning behavior. Finally, the study will help you to evaluate *quality* in living.

Selection of Material.—In using literature as source material, selection and wise guidance are very important; the value of the material depends on its authenticity and how well it meets the teaching purpose. Every assignment should have a specific objective, and the material should be adequate to cover principles

taught. Psychiatric content does not guarantee teaching value; and ignorance, stupidity, and immorality are not synonymous with a personality disorder.

Books of particular value are those that deal with ideas rather than action, emphasize the unfolding of character and the development of personality rather than plot, are keen and accurate observations of behavior, and present a sound development of the subject matter. Quality in writing should be considered. Generally speaking, the classics—books that have a timeless, ageless quality and are of universal and permanent worth—are the most serviceable. Some of the current psychological novels are well done; but the majority of them are “written down” to a popular level, particularly the ending, and are too diffuse for teaching purposes.

The literature suggested in this section deals chiefly with mournful and destructive aspects of human behavior or with failure. An approach may be made from a positive angle—a study of successful lives; however, portraits of unsuccessful living are closer to the patient picture on the ward, and a study of unsuccessful lives shows cause-and-effect relationships in behavior more clearly.

Method.—From the beginning, it is important to grasp that the story in the piece of literature selected for study is relatively unimportant and that the study is not a book review but an investigation of details as they relate to the whole person and his problem. Detail is all-important; however, a single item becomes significant only as it is viewed in relation to the whole. The work is slow. Continuity and value are seen best in retrospect. Furthermore, interpretations are personal opinions and differ with the knowledge and experience of the interpreter. Two outstanding procedures for study are the question form and the essay form.

In the question form, specific questions should be formulated by the teacher. In general, questions run something like this: What kind of people are the parents? What is the early environment? What is the nature of early training and education? Do the adults with whom the character is most intimate provide wholesome patterns? What are the character's potential abilities and capacities? How does he react to difficulty? What type of difficulty does he run into? Do physical symptoms such as nausea, vomiting, and headache follow disagreeable situations? Does the person have energy? How does he use this energy? On

what kind of things does he place value? Does he procrastinate? Are love affairs successful? What are his objectives in living? Does he have a working philosophy toward life? Are inner resources developed? Give specific examples of unwise behavior. Are these recognized? What situations or experiences early in life influence the behavior later on? What definite behavior trends develop? In what ways are these disadvantageous to the individual? To society? What forces are responsible for these trends? What general factors lead to unhappiness, inefficiency, or failure? If there is a specific objective in the assignment, the questions should focus around this and present a logical continuity regardless of the book's page sequence.

For the essay form, specific directions or pivotal questions should be provided. These directions or questions should guide mental activity toward significant points.

Specific Approaches for Study.—Specific approaches suggested for study are the following:

1. A particular book.
2. A single character.
3. A particular aspect (for example, fear).
4. Symptomatic behavior.
5. Comparative studies.
6. Mental hygiene.

If several approaches are used, only one at a time should be undertaken; the longitudinal view is important, and continuity of thought should not be interrupted.

A study of too much material or too many books should be avoided. In the beginning, an intensive study of one character or one book is better than superficial contact with several. One book usually contains only a few pertinent ideas, and this does not furnish a rich experience or contribute greatly to the total need; however, it directs thinking along realistic lines and opens the door to a large field for investigation of unhappy human lives.

A Particular Book. See outline for study of Flaubert's "Madame Bovary" in Appendix.

A Single Character.—A single character may be used for study (for example, Emma Bovary). In such an approach the material should show the development of the behavior which suggests the

study. Many of the characters named in the following pages are satisfactory subjects.

A Particular Aspect.—A particular aspect of the behavior of characters in books presents an interesting approach for study. The aspects considered here are fear, mental conflict, emotional immaturity, frustration, jealousy, selfishness, loneliness, suicide, and comfort versus happiness.

In dealing with life problems, fear can destroy equanimity. Study the behavior of Lady Macbeth ("Macbeth," William Shakespeare), Brutus Jones ("The Emperor Jones," Eugene O'Neill), Rodion Raskolnikov ("Crime and Punishment," Feodor Dostoevsky), Anna Karenina ("Anna Karenina," Count Leo Tolstoy), and Beret Holm ("Giants in the Earth," O. E. Rölvaaag).

The plot of the first three books is almost identical—a person is associated with a crime and then suffers to the breaking point.

Mental conflict, an inner struggle between two opposing forces, is a timeless, ageless human experience. Conflict is a part of life. Even the little boy at the circus with a nickel to spend has to decide whether to see the cow with two heads or buy a hot dog. Conflicts may be superficial and easily recognized, or they may be deep and not understood by the average observer or even the individual himself. In psychiatry, the inability to resolve the conflict is of most interest.

For study, consider the behavior of Ophelia and Hamlet, ("Hamlet," William Shakespeare), Oedipus ("Oedipus Rex," Sophocles), Margaret ("Faust," Johann Wolfgang von Goethe), Captain ("The Father," August Strindberg), Louis ("Salavin's Journal," Georges Duhamel), Anna Karenina ("Anna Karenina," Count Leo Tolstoy), Javert ("Les Miserables," Victor Hugo), Nora ("A Doll's House," Henrik Ibsen), Scrooge ("A Christmas Carol," Charles Dickens), and every character in "Leonardo da Vinci," Dmitri S. Merejkowski.

Emotionally immature adults are invalids in the business of living. There are marked differences in degree; however, fundamentally they are passive, superficial, irresponsible, and undependable. They are impulsive. They laugh easily and seem calm, but actually they are easily annoyed and have a continual unrest. They have no faith in themselves. They lack purpose in living and have a limpness of character which causes them to yield quickly to even mild pressure and to fold up in the face of real trouble.

For illustrations of emotional immaturity study the following characters: Charles Bovary (see Appendix), Dora Copperfield ("David Copperfield," Charles Dickens), Victor Campion ("The Perennial Bachelor," Anne Parrish), Paul Morel ("Sons and Lovers," D. H. Lawrence), May Beringer ("The Old Ladies," Hugh Walpole), Clare Rossiter ("Fortitude," Hugh Walpole), and Erlend Nikulaussön ("Kristin Lavransdatter," Sigrid Undset).

For illustrative material on frustration, study the behavior of Ethan Frome ("Ethan Frome," Edith Wharton), Charlotte Lovell ("The Old Maid," Edith Wharton), and Robert Leckie ("The Green Years," A. J. Cronin).

Selfishness is a human characteristic or trait that tends toward isolation, sterilization, self-destruction, and the destruction of others. Study selfishness as evidenced in the behavior of Julien Sorel ("The Red and the Black," Stendhal), the Senator ("Les Misérables," Victor Hugo), Becky Sharp ("Vanity Fair," William Makepeace Thackeray), Silence Withers ("The Guardian Angel," Oliver Wendell Holmes), Anastasie and Delphine ("Père Goriot," Honoré de Balzac), and Goneril and Regan ("King Lear," William Shakespeare).

Many lives are crippled or ruined through parental selfishness. Everyone understands that parents sorrow and sacrifice for their children; but not enough is known about the way in which children sorrow and sacrifice for their parents.

Parents who lack satisfaction in living attempt to meet their own emotional needs by devouring their children. They demand continual priority in affection, energy, and earnings. This is something quite different from the provision for parents in old age. It is a swallowing-up process that begins early in life, continues throughout the years, and ends in tragedy.

Examine the behavior of the following parents, the resulting family unhappiness, and the ill effect on the children: Madame Bovary, senior (see Appendix), Sir Austin Feverel ("The Ordeal of Richard Feverel," George Meredith), Edward Barrett ("The Barretts of Wimpole Street," Rudolf Besier), Friedrich Wieck ("Spring Symphony," Eleanor Paintor), Gertrude Morel ("Sons and Lovers," D. H. Lawrence), Gunhild Borkman ("John Gabriel Borkman," Henrik Ibsen), Darius Clayhanger ("Clayhanger," Arnold Bennett), Edward Tulliver ("The Mill on the Floss," George Eliot), M. Grandet ("Eugénie Grandet," Honoré de

Balzac), Mrs. Thrift; Mrs. Payson ("The Girls," Edna Ferber), and M. Duval ("Camille," Alexandre Dumas fils).

It is in reading about selfishness as illustrated by the previous characters that one is able to grasp its meaning, its various manifestations, the fact that it is always well-cushioned and hard to reach, and to understand its effect on people, how others react to it, and how it destroys. There is such a thing as intelligent selfishness wherein the individual develops inner resources that he does not divide with the rest of the world and in which he finds consolation and inner strength. For an example, examine Voltaire's "Candide." However, in general selfishness is destructive.

Jealousy disturbs equilibrium and destroys life. Study the behavior of Othello ("Othello, the Moor of Venice," William Shakespeare), Leontes ("Winter's Tale," William Shakespeare), Pozdnuishef ("The Kreutzer Sonata," Count Leo Tolstoy), Ellen Berent ("Leave Her to Heaven," Ben Ames Williams), and Mrs. Danvers ("Rebecca," Daphne du Maurier).

Loneliness as found in patients on the psychiatric ward is an isolation of spirit. Study the behavior of Stephen ("The Well of Loneliness," Radcliffe Hall), Ivan ("The Death of Ivan Ilitch," Count Leo Tolstoy), Eugénie, Mme. de Bonfons ("Eugénie Grandet," Honoré de Balzac), and Elsie Venner ("Elsie Venner," O. W. Holmes).

Suicide is a prevalent problem of the world in general and the psychiatric ward in particular. For a better understanding, study the behavior of Emma Bovary (see Appendix), Anna Karenina ("Anna Karenina," Count Leo Tolstoy), Javert ("Les Misérables," Victor Hugo), Brutus Jones ("The Emperor Jones," Eugene O'Neill), Ellen Berent ("Leave Her to Heaven," Ben Ames Williams), Hetty Sorrel ("Adam Bede," George Eliot), Gwynplaine ("The Man Who Laughs," Victor Hugo), Gösta Berling ("The Story of Gösta Berling," Selma Lagerlöf), Paul Morel ("Sons and Lovers," D. H. Lawrence), Hedda Gabler ("Hedda Gabler," Henrik Ibsen).

Happiness and comfort are not synonymous terms. Happiness is wholly internal. It is a quiet inner confidence that follows the resolution of inner tensions and arises from strength of soul. Comfort has a superficial aspect; it comes from without. Probably it should be described as an absence of striving and being thwarted.

Some people go through life without apparent struggle. These people may be good citizens, in fact they usually are, and they may be successful from a materialistic point of view; but they are not deep, rich, full personalities. They lack discernment in human affairs. Their good characteristics have a shallow, passive quality and are present often more from cowardice or a lack of opportunity than from refinement and discrimination.

Many people are unwilling to suffer discomfort for the sake of later greater comfort; but there is no real progress without discomfort, no self-realization and wholesome satisfaction without pain, no deep inner peace without suffering.

For ideas on comfort examine the behavior of Charles Bovary (see Appendix), Dirk de John ("So Big," Edna Ferber), and H. M. Pulham ("H. M. Pulham, Esquire," John P. Marquand).

For ideas on happiness (peace), examine the behavior of Faust ("Faust," Johann Wolfgang von Goethe—Part II is necessary), Jean Valjean ("Les Misérables," Victor Hugo), Pierre Bezuhov ("War and Peace," Count Leo Tolstoy), Sonia Marmelodov ("Crime and Punishment," Feodor Dostoievsky), Hester Prynne ("The Scarlet Letter," Nathaniel Hawthorne), and Konstantin Levin ("Anna Karenina," Count Leo Tolstoy). These people all live vital, virile, stormy lives; they suffer; they go through a period of chaos; but they finally find peace in faith and in work, particularly in helping others.

Symptomatic Behavior.—Many characters in books illustrate symptomatic behavior and the development of this behavior. A study of the following characters is suggested; they are divided into two groups according to the types of behavior that they illustrate, namely, psychotic and pernicious.

The behavior of the first group of characters suggested below shows (1) a lack of balance in the person's relationship to others, (2) a definite disorganization of the personality, and (3) the development of this disorganization. (The evaluation as to specific reaction types, for example the schizophrenic reaction type, is not important.) They are Margaret ("Faust," Johann Wolfgang von Goethe), Beret Holm ("Giants in the Earth," O. E. Rölvaag), Captain ("The Father," August Strindberg), Ophelia ("Hamlet," William Shakespeare), Lady Macbeth ("Macbeth," William Shakespeare), Louis ("Salavin's Journal," Georges Duhamel), Dr. Richard Mahoney ("Ultima Thule,"

Henry Handel Richardson), Albert, Count of Rudolstadt ("Consuelo," George Sand), Alessandro ("Ramona," Helen Hunt Jackson), Adrienne Mesurat ("The Closed Garden," Julian Green), Irene ("When We Dead Awakened," Henrik Ibsen), Foma ("Foma Gordyeff," Maxim Gorky), and Selie Minoret ("The Human Comedy," Honoré de Balzac).

The second group of characters are named to illustrate behavior which prevents self-realization and satisfaction in living. There is definite self-defeat; however, there is no radical change and no decided break with society. The characters are: Julia ("Countess Julia," August Strindberg), Katerina Ivanova ("Crime and Punishment," Feodor Dostoievsky), Lise Hohlakov ("The Brothers Karamazov," Feodor Dostoievsky), Nastasya Filippovna Barashkov ("The Idiot," Feodor Dostoievsky), Stanley Timberlake ("In This Our Life," Ellen Glasgow), John Gabriel Borkman ("John Gabriel Borkman," Henrik Ibsen), Nina Leeds ("Strange Interlude," Eugene O'Neill), Myrtle Hazard ("The Guardian Angel," Oliver Wendell Holmes), and Masha ("The Three Sisters," Anton Chekhov).

The following group of characters are semi-invalids whose physical ills are caused either all or in part by emotional factors: Lavina Timberlake ("In This Our Life," Ellen Glasgow), Aunt Leonie ("Swann's Way," Marcel Proust), Zenobia Frome ("Ethan Frome," Edith Wharton), and Count de Mortsau ("The Human Comedy," Honoré de Balzac).

Comparative Studies.—Comparative studies of individual behavior reveal universal aspects. When you have several fictional characters in mind, it is interesting to compare them to each other and to patients on the ward. Differences are always apparent; but when detailed aspects of behavior are dismissed and central points brought forward, similarities are recognized.

The books "Madame Bovary" and "Anna Karenina" do not strike the reader as repetitious and yet, in essence, the lives of these two women are alike: An unhappy marriage creates a crisis, and there is a suicidal termination to the unsuccessful attempt to meet the life problem. Differences relate to detail only. For example, compared with Emma Bovary, the general tone of Anna Karenina's behavior is on a higher social plane: Anna has but one lover, Anna handles her situations with greater delicacy, Anna has more insight and stronger emotional upheavals

relating to guilt and fear, and Anna makes a more evident struggle to follow the path of duty and the demands of society. The detailed differences between the actions of the two women are many; however, they point to one outstanding fact: Anna is an aristocrat.

Emma Bovary and Anna Karenina were not insane, but if their suicidal attempts had been unsuccessful, they would be hospitalized today. The psychiatric wards house many patients with histories not unlike those of these two unhappy women. A comparison was made previously between these two women and psychiatric patients, also between Lady Macbeth, Nana, Lucy Desborough ("The Ordeal of Richard Feverel") and patients. (See discussion of understanding behavior, page 76.)

In these studies attention to detail is the working potential; but out of this attention to detail comes a recognition of similarities in the characters studied to the people found on the hospital ward, their life problems and behavior reactions. The observation of detail provides the foundation for sound judgment and freedom in knowledge. When similarities are recognized, nursing care is much easier, because you cease to hunt so frantically for the meaning of what you see. The range of mental action is reduced. Ideas are greatly increased, but helpful conclusions are reached more quickly, and this saves time and energy for the refinement of essentials in nursing care.

Mental Hygiene.—"Mental hygiene is the science and practice of attaining and maintaining soundness and vigor of mind."¹ This science is concerned primarily with successful living, or the way in which man wins in the continual conflict with his environment. The mental hygiene aspect is demonstrated best in books in which the character appears first as a child and the material presents the development of attitudes, habits, prejudices, thoughts, and feeling states that work for or against him. Specific approaches for study are: (1) unsuccessful living and (2) successful living.

A study of human failure draws attention to pitfalls, or actions to be avoided. Most of the characters cited in this section offer possibilities for consideration from this point of view. For a detailed study see material on "Madame Bovary," in Appendix.

¹ The National Committee for Mental Hygiene, Inc.: Annual Report, 1944 page 1.

Successful living may be seen best in biography and in descriptions of inner struggles in "attaining and maintaining soundness and vigor of mind."

Usually biographies are written by or about people of recognized achievement or fame, and this tends to misrepresent the true meaning of success; also, the point of view is often biased. Biographies such as the following are especially helpful: "A Mind That Found Itself" by Clifford Beers,¹ "Autobiography" by John Stuart Mill, "The Little Locksmith" by Katharine Butler Hathaway, "Father and Son" by Edmund Gosse, "And Now to Live Again" by Betsy Barton, and "Campus Shadows" by Harold W. Trott.

All books are biographical to a certain extent, and the ones that help most in this particular kind of study are those that show wholesome reactions to universal human problems and particularly to the inner battle with the dualism of life. The following characters are suggested for study: Faust ("Faust," Johann Wolfgang von Goethe—Part II is important), Jean Valjean ("Les Miserables," Victor Hugo), Pierre Bezuhov ("War and Peace," Feodor Dostoevsky), Ernest Pontifex ("The Way of All Flesh," Samuel Butler), and Peter Westcott ("Fortitude," Hugh Walpole).

A study of successful lives indicates that self-realization and effectual adult behavior are the outcome of a gradual development of positive qualities, that the resolution of inner tension is a deep, continuous process, that in happiness the individual bends to meet external demands but remains still and strong inside.

MUSIC

Therapeutic Properties.—Music has therapeutic properties. Some hospitals have a full-time music director and are making special studies in this field; possibly some day music prescriptions will be established.

In general, marches, fast dances, and overtures are stimulating. Simple melodies in minor keys are restful. To arouse interest, select musical compositions that are familiar (pleasurable recognition), especially those written by composers of the patient's

¹This is a historically important autobiography; the epilogue gives information on the founding of the National and International Committees for Mental Hygiene, and the American Foundation for Mental Hygiene.

particular nationality, and that are the patient's particular choice—chamber, symphony, violin, piano, or voice. Even very ill patients respond to rhythm.

Music such as that characteristic of the slow movements of the works of Beethoven and Brahms does something toward giving inner peace. When patients become familiar with these particular works, they ask for them over and over again and are more quiet, more attentive, more moved than the average concert audience.

The appeal in music is not confined to listening, and contributory therapeutic values go beyond recreational aspects. Listening to Bach fugues as a study of musical logic, or the analysis of a composition such as the Schumann A Minor Piano Concerto, is a highly intellectual experience. In fact, music touches all phases of life—instinctive, emotional, intellectual, spiritual, cultural, and social. You are not expected to study music as a nursing measure; but if you have knowledge or ability in this field, you will be pressed to use it for the benefit of patients.

Radio. The use of radios and record players on the ward is often left to the nursing personnel. These instruments are of some value; they also have limitations.

Radios should not be turned on and left indefinitely. A single patient's favorite record should not be played over and over again to the exclusion of others.

Programs should be played or tuned in at definite times and should be planned to reach a wide range of patient interests and needs. Points for consideration are (1) type of music—popular, semiclassical, classical; (2) kind of music—voice, a single instrument, chamber, orchestra; (3) predominant musical pattern—rhythm, melody, harmony; and (4) form—song, sonata, concerto, symphony, opera.

In program planning make a survey of patients on the ward—number, sex, ages, nationalities, behavior reactions (depressed, elated), and types of music preferred. Inform the patients regarding music or programs available, and ask for requests. Study requests, especially repeat requests. Read the publications that are beginning to appear on music therapy; also, make your own observations concerning the therapeutic effect of special music on a particular patient.

Music after Supper.—After the patients have had their supper, especially during the winter, is a splendid time for good music—

trios, concertos, symphonies; if you do not use an entire composition, use the more melodic parts. During some evenings have a group of patients gather around a piano and sing well-known songs. These are purposeful activities that loosen emotional tension and make for pleasant contact of the patients with reality and with each other; sometimes anxiety is diminished for the time being. In general, music after supper is helpful in promoting sleep.

Music for Church Services.—Church services are held regularly in the large hospitals for the mentally ill, and music is an essential part. The responsibility of supplying music for these services is frequently met by the nursing personnel.

In meeting the need, certain practical problems arise. The principal objective is to furnish a devotional atmosphere, but this is hard to bring about because sacred music for the piano (only a few hospitals have a pipe organ) is comparatively limited, and the instrument itself is not the one of choice for this particular purpose.

For the desired organ effect from a piano, work for power and sonority of tone, by paying special attention to chords and pedaling. The singers should leave chords slowly; and, in pedaling, an "overlapping"¹ pedal should be made use of for heavy vibrating chords. Chords should be played in a legato style without using the pedals—Mendelssohn's Opus 30, E major, "Consolation," from "Songs Without Words," is useful for practice. Sometimes, especially when there are many notes to the bar, it is advisable to reduce groups of notes to their respective chords.

Examine the classics for possible suitable piano music. A great deal of material is satisfactory as it is, especially that which is played at a slow, sustained tempo. Notice also how some compositions suggest a religious influence when played more slowly than indicated; this is particularly true of some of the music of Brahms.

A list of such compositions written or transcribed for the piano is included in the Appendix.

¹ "Hold the pedal an instant after the singers have taken the new chord, before taking a fresh pedal," Mrs. A. M. Virgil: "The Piano Pedals," The Virgil Piano School Company, New York, 1912, page 26.

REFERENCES: ART

- BOSWELL, PEYTON, JR.: "Modern American Painting," Dodd, Mead & Company, Inc., New York, 1939.
- GARDNER, ERNEST A.: "A Handbook of Greek Sculpture," The Macmillan Company, New York, 1909. (Laocoön group, page 471.)
- KNACKFUSS, H., et al.: "Rembrandt," in "Monographs on Artists," No. III, H. Grevel & Company, London, 1899.
- MEIER-GRAEFE, JULIUS: "Vincent Van Gogh. A Biographical Study," Hareourt, Brace and Company, New York, 1933. (Besides the self-portraits, Chapter 7, the first few pages describing the asylum of Saint-Remy is of particular interest.)
- ROSENBERG, ADOLF: "Leonardo da Vinci," in "Monographs on Artists," No. VII, Bielefeld and Leipzig: Velhagen & Klasing, 1903. ("The Last Supper," pp. 68-69; studies of individual heads appear on nearby pages.)
- SHOOLMAN, REGINA and CHARLES SLATKIN: "The Story of Art. The Lives and Times of Great Masters," Haleyon House, New York, 1940.
- SHOOLMAN, REGINA and CHARLES SLATKIN: "The Enjoyment of Art in America," J. B. Lippincott Company, Philadelphia, 1942.

REFERENCES: MUSIC

BOOKS

- COPLAND, AARON: "What to Listen for in Music," McGraw-Hill Book Company, Inc., New York, 1939.
- ERSKINE, JOHN: "A Musical Companion," Alfred A. Knopf, New York, 1935.
- SCHOLES, PERCY A.: "The Oxford Companion to Music," Oxford University Press, New York, 1942.
- SPAETH, SIGMUND: "The Art of Enjoying Music," Garden City Publishing Co., Inc., New York, 1938.
- STOKOWSKI, L.: "Music for All of Us," Simon and Schuster, Inc., New York, 1943.
- WELCH, ROY D.: "The Appreciation of Music," Harper and Brothers, New York, 1945.
- VAN DE WALL, WILLIAM and CLARA LIEPMAN: "Music in Institutions," Russell Sage Foundation, New York, 1936.

ARTICLES

- ALTSHULER, IRA M. "The Past, Present and Future of Musical Therapy," *Educational Music Magazine*, January-February 1945, pp. 16-17ff.
- ALTSHULER, IRA M. "The Part of Music in Resocialization of Mental Patients," *Occupational Therapy and Rehabilitation*, April 1941, pp. 76-79.
- ALTSHULER, IRA M. "Four Years Experience with Music as a Therapeutic Agent at Iloise Hospital," *The American Journal of Psychiatry*, May 1944, pp. 792-794.

- CORIAT, ISADOR H. "Some Aspects of a Psychoanalytic Interpretation of Music," *The Psychoanalytic Review*, October 1945, pp. 408-418.
- FULTZ, A. FLAGLER. "Music as a Modality-Occupational Therapy," *War Medicine*, March 1944, pp. 139-142.
- HANSON, HOWARD. "A Musician's Point of View Toward Emotional Expression," *The American Journal of Psychiatry*, November 1942, pp. 317-340.
- HARRINGTON, ARTHUR. "Music as a Therapeutic Aid in a Hospital for Mental Disease," *Mental Hygiene*, October 1939, pp. 601-609.
- MONTANI, ANGELO. "Psychoanalysis of Music," *The Psychoanalytic Review*, April 1945, pp. 225-227.
- SIMON, CAPT. WERNER. "The Value of Music in the Resocialization and Rehabilitation of the Mentally Ill." *The Military Surgeon*, December 1945, pp. 498-500.

APPENDIX I

OUTLINE FOR STUDY OF FLAUBERT'S "MADAME BOVARY"

This book may not be pleasant reading, but it has teaching possibilities because (1) it is true to life, (2) it has logic, (3) the pernicious behavior and its development are easy to recognize, and (4) the subject matter is not unusual.

The characters chosen for consideration here are Emma Rouault-Bovary and Charles Bovary. Neither Emma nor Charles Bovary is insane, however, they never become effectual persons with a solid satisfaction in living. They are mentally unhealthy, unhappy adults. Positive potentials are evident, but the Bovarys do not succeed in attaining even a fair amount of success, happiness, and efficiency. These characters make splendid study material from a standpoint of mental hygiene and the understanding of patients. You will recognize the substance in situations and reactions as similar to that found in many patient histories.

EMMA ROUAULT-BOVARY

Reason for Study.—Emma Bovary illustrates the tragedy of boredom. She is unable to find order and stability in life; she longs for happiness but has no technic for attaining it. Her unwise behavior, particularly her inability to introduce interest into an uninteresting environment, destroys her.

Some General Questions.

Give significant points regarding the parents.

What kind of person is Emma Bovary?

What were her ambitions and longings?

What kind of difficulties did she experience?

How did she react to difficulties?

What were her ideas of success and happiness?

Why did she fail to live richly and fully?

Detailed Questions.—For a detailed study of Emma Bovary the following questions and answers are supplied. Study the significance of the answers concerning the mental and emotional life of Emma Bovary.

Question: What was the parent-child relationship?

Answer: Neither parent was available as a love object (important).

1. There is very little information on the mother; she died when Emma was twelve years old. When the mother died, Emma felt no real sadness.

2. The father's primary interests were good food and a comfortable bed, he preferred to be alone. He was kind. When Emma was thirteen, he placed her in a convent. He was glad to get rid of Emma through her marriage; she was neither useful to him nor a companion in the home.

Question: What are some of Emma Bovary's outstanding characteristics?

Answer: She is selfish, superficial, insincere, easily influenced, sentimental, cowardly, docile, undisciplined, emotionally immature, lacking in inner strength.

1. She was interested in personal profit; a thing was useless unless it contributed to her immediate desires.
2. She was especially imaginative and fanciful.
3. She loved the church for the sake of the flowers, and literature for its passionnal stimulus; she could not accept discipline.
4. She changed residence; moving amused her.
5. She lacked grit and will power; she wanted a son, and her reaction to learning that she had given birth to a daughter was to faint. She often fainted. When convalescing from an illness she sat in the garden on the seat where her lover had sat; this association caused a relapse. She felt the need to lean on someone else who was strong (husband, a weak individual).
6. She affected anxiety, tenderness, and repugnance.
7. M. Boulanger, later her lover, describes her as follows: ". . . she sits there botching socks. And she gets bored! She would like to live in town and dance polkas every evening. Poor little woman! She is gaping after love like a earp after water on a kitchen table. With three words of gallantry she'd adore one."
8. Praise and flattery make her forget everything else.
9. Her last living act was to view herself in the mirror.

Question: While growing up, what did she do for recreation?

Answer: She played very little. Her recreation was chiefly extra study.

Question: What are her ideas on love?

Answer: Passionate rhymes, melancholy adagios, sighs by moonlight, long embraces, thick carpets, and silken curtains.

Question: Does she find pleasure in commonplace things?

Answer: She is distressed by ordinary things—homey people, simple pleasures. She does not discover pleasure in responsibility to duty—husband, child, home.

Question: What are her values in living?

Answer: She places primary value on personal appearance, good-looking clothes, and such things as golden knobs on canes, tapestry hangings, and velvet boots.

Question: What are her objectives in living?

Answer: Excitement, masked balls, and violent pleasures.

Question: During adolescence, what points stand out?

Answer:

1. An old maid, who came to the convent to mend linen, introduced her to colorful stories; after that she read books from which she could find imaginary satisfaction for her own desires (Balzac, Sand). She reveled in love novels and was specially attracted by stories of illustrious or unhappy women. She developed exaggerated or incorrect ideas on things outside the convent.
2. She had the customary indefinable uneasiness of adolescence, but her loose inner feelings never became attached to anything or anyone solid and worth-while.
3. "Her life was cold as a garret whose dormer window looks on the north, and ennui, the silent spider, was weaving its web in the darkness in every corner of her heart."

Question: Is her reasoning and judgment sound?

Answer:

1. At one time she reasoned that since the portion of her life lived had been bad, no doubt that which remained would be better.
2. When in delirium she was reassured by the largeness of the sun.
3. When in trouble she expected some extraordinary event would come to her rescue.

Question: Is she stupid?

Answer: At school she knew her lessons well; she was the one always to answer the most difficult questions.

Question: What are her ideas of happiness?

Answer: Rapture, passion, ecstasy, and delirium.

Question: Is her behavior motivated primarily by intelligence, emotion, or a fair combination of the two?

Answer:

1. She rejected as useless all that did not contribute to the immediate desires of her heart; she looked for emotion.
2. She could not view things objectively, for she was always carried away by the emotion of the moment.
3. The things that mattered always related to a present emotional need.

Question: Does she deal with matters as they are?

Answer:

1. The nearer things were the more her thoughts turned away from them; when at home, she wanted to be at school; when at school, she wanted to be home; when she lived in the country, she wanted to live in a town; when she lived in a town, she wanted to live in Paris; she lived quietly but wished for excitement; when she was single, she wished to be married; when she was married, she wished she were single or married to another man.

2. She considered the male sex more fortunate: "A man, at least, is free . . . but a woman is always hampered. At once inert and flexible, she has against her the weakness of the flesh and legal dependence. Her will, like the veil of her bonnet, held by a string, flutters in every wind; there is always some desire that draws her, some conventionality that restrains." (Evidence of conflict.)
3. Regrets and memories were her constant companions.
4. She lived with her dreams.
5. She wanted to travel; she had the persistent idea that happiness was always somewhere else.
6. Her desires were always out of line with possible attainments.

Question: Shortly after their marriage, Emma Bovary and her husband attended a ball given by a wealthy neighbor. What later events show that this continued to influence her life?

Answer:

1. She named her child Berthe because it was the name of a person whom she had met at the ball.
2. Her lover Rudolphe impressed her at first because he reminded her, on account of his dress and manners, of a viscount she had met at the ball and who now occupied her thoughts.
3. She gave her lover a cigarette case exactly like the one the viscount had owned.

Question: Why would Emma, or almost any woman, be unhappy with Charles Bovary for a husband?

Answer: Charles Bovary is emotionally immature (see following study). Charles and Emma were unable to discuss anything of a serious nature. Their marriage did not have a solid foundation. (This is the theme of Ibsen's "A Doll's House," see discussion of conflict, page 302.)

Question: When Emma realizes that she is not happy, does she look on the matter as a problem or show a will to win?

Answer:

1. She compares Charles to an imaginary husband. (This makes Charles even less desirable and herself less tolerant with him.)
2. She thinks constantly on what might have been.
3. She waits for something to happen.
4. She is not able to help herself. She accepts the position of loser — drops her music, gives up drawing and embroidery, lets her housework go, and lets down in the care of her personal appearance.

Question: Give symptoms of change.

Answer:

1. She was pale and had palpitation of the heart; she was growing difficult and capricious; she scolded her servants, then gave them presents; she was talkative and overexcited.

2. She showed rage, hatred, and evidence of fear.
3. She resorted to deception and trickery and evidenced emotional instability (laughed, cried, sent for sherbets, wanted to smoke cigarettes); she stole and had fits of temper.
4. She expressed a desire not to be alive, or to be always asleep.
5. She lost pride and all fineness of feeling.

Question: Regarding Emma Bovary's love affair with Rudolphe Boulanger, why is it unsuccessful?

Answer:

1. Rudolphe Boulanger had no depth of feeling for her.
2. As soon as the love affair was under way, Emma Bovary took the initiative.
3. She was unable to realize that the lover was calculating.
4. She became indiscreet.
5. She gave too much of herself—reduced her value.
6. She was unable to appreciate (accept) that her lover was growing tired of her.
7. She experienced fear for the loss of her lover; fear made her a coward and motivated the following unwise behavior:
 - a. She gave presents to Rudolphe—lost his respect.
 - b. She showed doubt of his love and probed into his past and present affairs—caused irritation and resentment.
 - c. She made demands such as exchanging miniatures and locks of hair, thinking of each other at certain times—hampered his freedom.
 - d. She increased the expression of her own love —this made her a nuisance.
 - e. She forced an issue—this made Rudolphe uncomfortable.

Question: In the second love affair, with Leon Dupuis, is there a repetitive behavior pattern?

Answer: The behavior pattern in the love affair with Leon Dupuis is almost identical to that with Rudolphe Boulanger. Before Emma Bovary's love affair with Rudolphe Boulanger, she had had a short uneventful affair with this same Leon Dupuis, and the essence of her behavior later on can be seen at that time.

Question: Is Emma Bovary simply an immoral, no-good woman?

Answer:

1. She tried to be a good wife. She was a good housekeeper, she prepared a good meal, she sent out her husband's bills "nicely phrased."
2. In accord with theories she believed right, she wanted to make herself in love with Charles.
3. She was married several years before difficulties arose.
4. She did not seek the first extramarital affair; she was in a mood to be attracted to somebody.

Question: Does Emma Bovary appreciate that she is unsuccessful in living?

Answer:

1. She experiences an insufficiency in life; "she was not happy, never had been."
2. She is unbearable to herself.
3. She realizes that her husband, whom she looked upon as undesirable, is superior to herself. (There is a similar point in Javert, in "Les Misérables," see discussion of conflict, page 302.)

Question: How does Emma Bovary behave in the face of trouble?

Answer:

1. She gave up interests and became capricious.
2. She was eaten up with rage, hatred, self-pity, and fear; she began to show confusion.
3. Anger and fear were evident; she thought of suicide.
4. The termination of her love affair with Rudolphe brought on a long illness of uncertain character and complex symptoms—giddiness; vague complaints in chest, head, and limbs; vomiting.
5. She gives excessively to charity.
6. She is resigned.
7. Fits of temper are frequent.
8. Hatred is pronounced.
9. She commits suicide. (Her problem grew bigger and bigger, and she was less and less able to cope with it; finally, she is desperate and suicide is the only means of escape; notice the gradual extension of unsuccessful behavior reactions.)

Question: Is it an accident that Emma Bovary destroys herself?

Answer:

1. Her early life does not provide a sound foundation for successful living.
2. She cannot accept discipline.
3. She cannot deal with things as they are.
4. Her objectives in living are of a light, flexible, temporary nature.
5. Her mental activity has a superficial quality; gay ideas run around in an undeveloped mind; she holds on to the pleasure principle of childhood and never learns to "prize other joys."
6. She always depended on outside things—parties, activities, stimulation, other people.
7. She does not find strength and satisfaction through a development of inner resources.

Summary.—Emma Bovary is not insane; but she is decidedly unsuccessful in the business of living. She never becomes rich and solid inside and yet she had positive potentials. In adult life she sees happiness in terms of the pleasure principle of childhood. Her judgment in values is nil. She is wholly unable to salvage any happiness in an unhappy situation. Her marriage to an emotionally immature man creates a crisis but merely indicates a deeper problem—her inability to deal with life. Defeat and destruction lie within herself.

CHARLES BOVARY

Reason for Study.—Charles Bovary's life is an illustration of emotional immaturity and the tragedy inflicted by a possessive parent.

Pivotal Questions for Essay.

Pick out characteristics pointing to emotional immaturity.

Why is Charles Bovary emotionally immature?

Why does he marry Emma Rouault?

Why is he unable to appreciate his wife's problem?

When he is forced to face trouble, why does it crush him?

Essay.

Charles Bovary's life illustrates emotional immaturity and the tragedy inflicted by a possessive parent. All his life he keeps away from activity (life), and he avoids anything that is harsh or unsympathetic (reality). He lives comfortably, but he never experiences self-realization and a quiet confidence with a deep, rich, inner peace.

Unhappy in her marriage, Charles' mother centers her entire life on him and "sorrows and sacrifices" to make him what he is. He goes to medical school because "Mama" says so, he opens a practice in a certain town because she makes the plans; he even marries a woman many years his senior because she is the one his mother picks out for him.

Charles is not happy with his first wife—he could not be happy, because his mother picked out someone who precluded competition. This wife died soon after the marriage, and his second wife, Emma, is of his own choosing; but the choice is based on beautiful eyes, full lips, rose-coloured cheeks, small feet, and proximity.

To the average person, Charles Bovary appears to be a fine man (and he is) and well equipped to meet life (but he is not). What is wrong with Charles Bovary? He is ineffectual, impotent. He is without curiosity, ambition, drive, and has a childlike simplicity that makes him blind. He lacks wisdom. He has talents but no desire to make use of them. He has no faith in himself, and his insecurity makes him seek protection in routine.

He provides safety for himself by always taking a middle ground—this does not offend or antagonize. Even as a physician, "being much afraid of killing his patients Charles, in fact, only prescribed sedatives, from time to time an emetic, a footbath, or leeches." To keep up with the times, Charles took a medical journal and read it a little after dinner, "but in five minutes, the warmth of the room added to the effect of his dinner sent him to sleep."

Charles Bovary has a stifling lethargy. His conversation is dull; he knows nothing, teaches nothing, wishes nothing. He has energy, but he cannot mobilize or utilize it for specific needs. His outward calm has a phlegmlike quality. He never goes to the bottom of things and shrinks from proofs. In minor home crises, he falls asleep, and when faced with important questions, he never weighs matters.

In the unsuccessful operation on the club foot (beginning with Chapter XI) he is moved into action by pressure from the local druggist and from his wife,

who does not know a thing about the matter but senses some possible glory for herself.

Charles Bovary is a good man; but even his goodness has a superficial quality. It is never directed toward specific goals, and there is no strength of spirit.

Throughout life, Charles Bovary feels insecure in every relation. His behavior pattern, established in childhood, is one of submission and dependency. He is wholly unable to deal with opposition in a mature way and is crushed when forced to face trouble. As an adult he is not manly in his aims and character, and from an emotional point of view he is an unfulfilled, unfinished product. During the formative years, development toward security and self-reliance was impossible because of the mother's possessiveness.

APPENDIX II

GLOSSARY OF TERMS¹

PSYCHIATRIC TERMS RELATING TO GENERAL APPEARANCE AND BEHAVIOR

abolement. Abnormal sounds produced involuntarily; often sounds resembling animals. Seen in schizophrenia.

aboulia (abulia). Inability to come to a decision; extreme indecision. Seen in neuroses, schizophrenia. Examples:

1. A patient holds his hat in his hand unable to decide whether to lay it down, hang it up, or put it on his head.
2. A patient is unable to get out of bed because he cannot decide which leg to put out first.
3. A patient cannot eat because he cannot decide which food to take first.

adephagia. Gluttony.

allo-eroticism. Eroticism (sexual instinct) directed to an external object.

ambivalence. Opposing emotions (such as love and hate) or emotional attitudes existing at the same time toward a definite object; opposite desires occur at the same time.

anhedonia. Apathy; a lack of pleasure in behavior that is usually pleasurable. **anorexia.** Loss of appetite.

astasia. Inability to stand, of psychic origin; seen in obsessive-compulsive states and in schizophrenia, especially catatonic type.

autistic thinking. Daydreaming.

auto-eroticism. Sexual instinct is directed to self; masturbation is a subdivision of auto-eroticism.

automatism. Activity without conscious purpose.

bestiality. Sexual intercourse with an animal.

boulimia. An inordinate appetite.

carphology. Aimless picking, usually at clothing, fingers, or bedclothes. Seen in senile dementia, delirious states, and before death.

catalepsy (cerea flexibilitas; waxy flexibility). Various waxlike postures are maintained for indefinite periods; the change in muscle tone may be waxy or tense. Seen in schizophrenia, catatonic type, and in hysteria.

cerea flexibilitas. See *catalepsy*.

cohabitation. Sexual intercourse.

coitus. Sexual intercourse.

¹ The arrangement of material relates to the "Outline for Observation of Behavior," page 45. Cross references to other terms in glossary are in italics.

coprophilia. An interest in feces.

cunnilingus. Sexual perversion, tongue or mouth to vulva.

debilitas erethistica. Morbid irritability.

dementia. Intellectual and emotional deterioration.

deterioration. A chronic progressive impairment of the intellectual faculties.

disintegration. Disorganization of psychic processes.

echopraxia. Imitation of movements as seen in others. Common in schizophrenia, catatonic type.

emotion. Strong feeling.

empathy. Intellectual identification.

enuresis. Involuntary passage of urine.

euphoria. Relating to a feeling of well-being.

exhibitionism. Sexual exposure; the exposure of the body or parts of the body or actions to attract sexual interest.

fabrication. Using imaginary events or situations as true, or using real events in a setting in which they do not belong. Found in organic brain disease.

fellatio. Sexual perversion; oral coitus; penis placed in mouth.

fixation. Fixation of psychic energy, refers to faulty development; large amount of energy remains fixed to infantile ways of finding pleasure.

fugue. A disturbance of consciousness; a form of behavior in which the person seems in possession of his mental faculties and yet does not know important points about himself or certain past experiences. Seen in hysteria, epilepsy.

furor. Abnormal rage. Seen in neurasthenia, epilepsy.

geophagia. Eating dirt.

hebetude. Emotional apathy; dullness of the special senses and intellect.

heterosexuality. Sexual love for a person of the opposite sex; the mature state of psychosexual development.

homogenitality. Sexual perversion; sexual practices involving the genitals of an individual of the same sex.

homosexuality. Love for a person of the same sex; a phase of psychosexual development—between narcissistic and heterosexual phases—about five to fifteen years of age.

hypalgesia. Decreased sensibility to pain.

hyperalgesia. Increased sensibility to pain.

hyperesthesia. Increased sensitivity.

hyperhidrosis. Pathological increase of perspiration.

hyperorexia. A morbid increase in appetite.

hypesthesia (hypoesthesia). Decreased sensitivity.

illusion. A misinterpretation of a real sensory impression; e.g., a bathrobe cord is mistaken for a snake.

incest. Cohabitation between persons so closely related that marriage is prohibited.

infantile. Childish behavior in a grown person (behavior of a child one to five years of age).

inhibition. An instinctual impulse unconsciously held in check or restrained by an opposing force. Seen in neuroses.

introversion. General tendency to be interested in thoughts and feelings instead of reality; interest mostly in inner life.

libido. Psychic energy.

malingering. Feigning an illness or injury.

mannerisms. Stereotyped movements; the repetition of a grimace or gesture without apparent reason.

masochism. Sexual pleasure or satisfaction in suffering, the suffering of self.

masturbation. Genital excitation of oneself; not confined to manual friction of the genitals; psychic masturbation—genital excitation stimulated by the mind.

mythomania. Pathological lying.

narcissism. Love of self; a phase (early) of psychosexual development; the person considers his own body as the love object.

negativism. Negative attitude or behavior; resistance. In active negativism the person does the opposite of what he is asked to do; e.g., if the patient is asked to open his mouth he shuts it tightly. In passive negativism the person does not do things he is expected to do, e.g., empty the mouth of saliva, the bladder of urine, etc.

nostalgia. Homesickness.

nostomania. Severe homesickness.

parapraxia. Symptomatic inaccuracies—slips of the tongue, forgetting to carry out intentions, mislaying objects.

pederasty. Sexual perversion, sexual practices between male human beings; anal coitus.

perseveration. The persistent repetition of an activity, e.g., walking around in a circle over and over again. Seen in schizophrenia.

perversion. Usually refers to sexual practices that are out of line with the normal or average, e.g., *cunnilingus*, *fellatio*, *homogenitality*, *pederasty*.

polyphagia. Gluttony; excessive eating.

rationalization. Behavior motivated from unconscious sources made to appear reasonable.

regression. Behavior reverses to an infantile or primitive character. According to Freud, mental development progresses through different levels of adaptation; regression refers to a return to an earlier level.

repression. The unconscious checking or holding back of thought.

retardation. A pathological slowing up of reactions. Seen in manic depressive psychoses, depressed phase.

sadism. Sexual pleasure or satisfaction in suffering, the suffering of someone else (pathological aggression).

schizoid. Like or resembling or pertaining to schizophrenia.

sodomy. Bestiality; sexual practices between man and animals (usually male human being and a female animal).

stereotypy. The persistent repetition of words or acts. Seen especially in catatonic schizophrenia during excitement.

sublimation. A change in the overt expression of instincts, particularly to a higher social level.

suggestibility. Abnormal susceptibility to suggestions which modify or change thought, feeling tones, action.

suppression. A conscious checking or holding back of thought.

symbolization. Something stands for or represents something else; there is generally a connecting link or similarity, although this can be overlooked easily.

thymopathy. Abnormal instability of emotion.

tic. A spasmotic or jerky movement caused by the contraction of certain muscle groups, e.g., blinking, twitching of facial muscles, head movements.

waxy flexibility. See *catalepsy*.

PSYCHIATRIC TERMS RELATING TO STREAM OF TALK

acataphasia. Inability to make words agree with the thought; words have only a sound connection.

agraphia. Loss of ability to put ideas in writing, may be due to organic or psychic factor.

allophasia. Incoherent speech.

aphasia. A disorder of speech; loss of power of speech or an inability to communicate thoughts, feelings, wishes. Subdivisions are *logaphasia* (motor) and *logamnesia* (sensory). See also *acataphasia*, *agraphia*, *aphrasia*, and *paraphrasia*.

aphonia. Speechlessness, usually used to indicate structural or organic origin.

aphrasia. Inability to understand a group of words connected as phrases or inability to speak.

barylalia. Husky, thick, indistinct speech. Seen in organic lesions in the central nervous system, common in advanced psychoses with syphilitic meningoencephalitis (general paresis).

baryphonya. Deep and hoarse voice.

battarismus. Stuttering, stammering.

blocking. A sudden stopping in the flow of speech (sudden cessation in a train of thought probably due to intense emotion, signifies conflict).

bradylalia. Slow speech. Seen in brain lesions.

circumstantiality. Before reaching the goal idea many irrelevant details and incidents are recited. Seen in mania and chronic alcoholism.

condensation. Emotional condensation—one idea or word brings forth all the emotion associated with several ideas; or ideational condensation—one word expresses several ideas.

confabulation. Filling in the gaps of memory with fabrications; imaginary experiences are given as true. A type of *paramnesia*.

coprolalia. The use of obscene words relating to feces or the symbolic representation of feces.

dysarthria. Imperfect articulation.

echolalia. Repetition of words or phrases used by others. Seen in schizophrenia.

embololalia. Words without meaning are scattered in a sentence.

flight of ideas. The goal idea is not reached, and there is a fragmentary stream of talk occasioned by thoughts that shift quickly from one direction to another.

logamnesia. Sensory aphasia (perceptive); the patient is unable to understand the meaning of words spoken or written.

logophasia. Motor aphasia (expressive); the patient understands but is unable to read aloud or express thoughts in words.

logorrhea. Excessive speech.

mogilalia. Stuttering; difficulty in speaking.

motor aphasia. See *logophasia*.

neologisms. New words or phrases coined by the patient.

paraphrasia. Words are spoken but misused; a condition of partial aphasia.

periphrastic. Use of unnecessary words to express an idea.

sensory aphasia. See *logamnesia*.

verbigeration. The morbid repetition of words, phrases, or sentences.

word salad. A flow of words and phrases that do not have an obvious connection. Seen in schizophrenia.

OTHER PSYCHIATRIC TERMS

acrophobia. Fear of high places.

agnosia. Loss or impairment of memory of an object.

agoraphobia. Fear of wide open spaces.

ailurophobia (galeophobia; gatophobia). Fear of cats.

amnesia. Loss or impairment of memory of an experience or a group of experiences.

anthropophobia. Fear of people.

aprosexia. Inability to hold attention.

arithmomania. A morbid impulse to count.

atephobia. Fear of ruin.

bathophobia. Fear of depths or of looking down from a high place.

claustrophobia. Fear of narrow or enclosed places.

compulsion. A chronic, insistent, unwished-for repetition of an act, due to an irresistible impulse in spite of opposition by the person's conscious will.

For definitions of some common compulsions see *arithmomania*, *ergasiomania*, *erotomania*, *erotographomania*, *kleptomania*, and *pyromania*.

delusion. A fixed, absurd false belief. Some common delusions are delusions of death, grandeur, negation, persecution, sin, and unworthiness. See also *expansive delusion*, *somatic delusion*, *megalomania*, and *theomania*.

delusion of grandeur. A false belief as to one's power or wealth; e.g., a man without money believes he has millions.

delusion of negation. The person denies what is real; this is a form of resistance.

delusion of persecution. A false idea relating to being persecuted, slandered, or injured. Seen in *paranoia*; *schizophrenic reaction*, *paranoid type*; and *involutional melancholia*. In the delusions of persecution as seen in the *schizophrenic reaction*, *paranoid type*, the person considers that he is an innocent victim (opposite of delusions seen in *involutional melancholia*).

dysmnesia. Impaired memory.

entomophobia. Fear of insects.

ergasiomania. A morbid impulse to keep going.

erotographomania. A morbid impulse to write love letters.

erotomania. A morbid impulse to make love.

erythrophobia. Fear of red—may represent blood.

expansive delusion. False belief relating to one's greatness or power.

hemophobia (hematophobia). Fear of blood.

hyelophobia. Fear of glass.

hypernesia. Unusual memory. Seen in *manic depressive psychosis*, *manic phase*.

hyperprosexia. Attention is entirely taken up with one idea; there is no room for other ideas.

hypoprosenia. Reduced attention.

kleptomania. A morbid impulse to steal.

megalomania. A delusion that one is great—Napoleon, the President of the United States.

monophobia. Fear of being alone.

nosophobia. Fear of disease, usually of a particular disease such as *syphilis* (*syphilophobia*).

obsession. An insistent unwished-for repetition of a thought, *e.g.*, a foul word or phrase.

ochlophobia (demophobia). Fear of crowds.

paramnesia. Distortion or falsification of memory; facts and phantasies are confused, intertwined.

phobia. A fixed, morbid fear; an obsessive fear. For definitions of some common phobias, see *acrophobia*, *agoraphobia*, etc., listed separately.

pyromania. A morbid impulse to set things on fire.

rhypophobia (rupophobia). Fear of dirt or filth.

somatic delusion. False idea in regard to changes in an organ of the body or its function.

thanatophobia. Fear of death.

theomania. A delusion that one is God.

zoophobia. Fear of animals.

APPENDIX III

COMPOSITIONS WRITTEN OR TRANSCRIBED FOR THE PIANO

Bach, Johann Sebastian.

"Jesu, Joy of Man's Desiring," the chorale from Cantata No. 147, piano arrangements by Myra Hess (Oxford), Leonard Borwick (Oxford), and Harold Bauer (Schirmer).

"Beloved Jesu, We Are Here," arranged by Harriet Cohen (Oxford).

"We All Believe in One God, the Father," organ chorale prelude, arranged by W. G. Whittaker (Oxford).

Largo, from Clavier Concerto in F Minor, arranged by Harold Craxton (Oxford).

"Komm, Süsser Tod" (Come, Sweet Death), choral melody, transcribed for the piano by Alexander Kelberine (Elkan-Vogel); Harold Bauer (Schirmer).

Adagio from Organ Toccata in C Major, No. 1, adapted for piano by Myra Hess (Oxford).

Prelude in B Flat Minor, from "The Well-Tempered Clavichord," No. 22, Vol. I.

Eight Organ Chorale Preludes ("Library of Musical Classics No. 1087," Schirmer).

"Eighteen Little Preludes and Fugues" (Schirmer No. 424).

"Twenty-one Short Preludes and Six Fugues" (Schirmer No. 15).

"Concerto in the Italian Style," Andante molto espressivo, 2nd movement. Chromatic Fantasy and Fugue in D Minor.

Prelude and Fugue in A Minor, for organ, transcribed for the piano by Liszt.

Fantastic and Fugue in G Minor, for organ, transcribed for piano by Liszt. Toccata and Fugue in D Minor, arranged for piano by Carl Tausig.

Beaumont, P.

"Slumber Sweetly."

Beethoven, Ludwig van.

Sonatas

1st Movement

Opus 26, A flat major, Andante con variazioni, theme.

Opus 27, No. 2, C minor ("Moonlight"), Adagio sostenuto.

Opus 49, No. 1, G minor, Andante.

2nd Movement

- Opus 2, No. 1, F minor, Adagio.
 Opus 2, No. 2, A major, Largo appassionato.
 Opus 2, No. 3, C major, Adagio.
 Opus 7, E flat major, Largo con gran espressione.
 Opus 10, No. 1, C minor, Molto adagio.
 Opus 10, No. 3, D major, Largo e mesto.
 Opus 13, C minor ("Pathétique"), Adagio cantabile.
 Opus 14, No. 2, G major, Andante.
 Opus 22, B flat major, Adagio con molto espressione.
 Opus 28, D major, Adagio.
 Opus 57, F minor ("Appassionata"), Andante con moto (the tendency
 is to play this movement too fast).
 Opus 79, G major ("Sonatine"), Andante.

Concertos for Piano

- No. 1, C major, Largo.
 No. 4, G major, Andante con moto.
 No. 5, E flat major ("Emperor"), Adagio.

Trio No. 7, B flat major, Opus 97, Andante cantabile.

Symphonies

- No. 5, C minor, Opus 67, Andante con moto, 2nd movement; also, Allo-
 gro, 3rd movement ("Analytic Symphony Series No. 3," edited and
 transcribed for the piano by Percy Goetschius, Ditson).
 No. 7, A major, Allegretto ("Analytic Symphony Series No. 26," Ditson).

Brahms, Johannes.

Three Chorale Preludes from Opus 122, for organ, transcribed by Harold
 Bauer (Schurmer): "My Faithful Heart Reposes," No. 1, "My Heart
 Is Filled with Longing," No. 10, "O World, I Now Must Leave Thee,"
 No. 11.

"Gestillte Sehnsucht" (Yearning), Opus 91, No. 1 Schurmer

"Geistliches Wiegenlied" (Holy Cradle Song), Opus 91, No. 2 (Schurmer
 Intermezzo in A Major).

Sonatas

- Opus 1, C major, Andante.
 Opus 2, F sharp minor, Andante.
 Opus 5, F minor, Andante espressivo, trio of the scherzo, intermezzo.
 Opus 4, Scherzo in E flat minor, Trios 1 and 2.
 Opus 9, Variations on a Theme by Robert Schumann, theme, variations 1,
 2, 14, 15, 16.
 Opus 10, Ballades, Nos. 1, 2, 3, 4.
 Opus 24, Variations and Fugue on a Theme by Handel
 Opus 83, Concerto in B Flat Major, Allegro appassionata, 2nd movement,
 Andante, 3rd movement.
 Symphony No. 3, F major, Allegretto, 3rd movement; also Andante, 2nd
 movement ("Analytic Symphony Series No. 33," Ditson).

Chaminade, Cécile.

Meditation, Opus 76, No. 6.

Chopin, Frederic F.

Preludes

Opus 28, Nos. 4, 6, 7, 15, 20.

Études

Nos. 3, 6, 19.

Nocturnes

Opus 9, No. 2

Opus 15, No. 2

Opus 37, No. 2.

Impromptu, C sharp minor ("Fantasie-Impromptu"), Largo (begins on the third page).

Debussy, A. Claude.

"La Cathédrale Engloutie" (Durand).

"Clair de Lune."

Prelude, A minor.

Delbruck, G.

"Berceuse," A flat major.

Dvořák, Anton.

"On the Holy Mount," Opus 18, No. 13.

Symphony No. 5, E minor ("New World"), Largo ("Analytic Symphony Series No. 9," Ditson).

Franck, César.

Prelude, Choral and Fugue (Schirmer No. 1232).

Symphony in D Minor, Lento, parts of 1st movement; Allegretto, 2nd movement ("Analytic Symphony Series No. 10," Ditson).

Godard, Benjamin.

"Lullaby" (Berceuse, from the opera "Jocelyn").

Gounod, Charles.

Meditation on the First Prelude by Bach ("Ave Maria").

Grieg, Edvard.

Sonata, E minor, Andante molto.

"Ase's Death," Opus 46, No. 2, First Peer Gynt Suite.

Gottschalk, Louis M.

"The Last Hope."

Handel, George F.

Largo from "Xerxes."

"Sarabande" from "Almira."

"Hallelujah" from "The Messiah."

Largo in E, from Concerto Grossso No. 12, arranged by Sir Henry Wood (Oxford).

Henselt, Adolf von.

"Ave Maria."

"Liebeslied."

Humperdinck, Engelbert.

"Evening Prayer" from "Hansel and Gretel," Act II.

Karganoff, Genari K.

"Berceuse," Opus 22, No. 3.

Kjerulff, Halfdan.

"Cradle Song," F sharp major (Century No. 3234).

Leybach, Ignace.

"Nocturne," No. 5, A flat.

Liszt, Franz.

Consolations

Nos. 1-4, inclusive.

"Ave Maria," F major.

MacDowell, Edward.

Opus 23, Second Concerto in D Minor, Larghetto calmato, 1st movement;

Largo, 3rd movement.

Malotte, Albert Hay.

"The Lord's Prayer," transcribed for the piano by Carl Deis (Schirmer).

Mascagni, Pietro.

Intermezzo from "Cavalleria Rusticana."

Massenet, Jules.

"Élégie," Melody in E minor.

Mendelssohn-Bartholdy, Felix.

Songs Without Words

Opus 19, A major, "Confidence."

Opus 30, E major, "Consolation."

Opus 38, A major, "Hope."

Opus 53, F major, "Sadness of Soul."

Opus 62, G major, "Morning Song."

Opus 67, E flat major, "Meditation."

Opus 67, B flat major, "Song of the Pilgrim."

Opus 85, F major, "Reverie."

Opus 85, D major, "Elegy."

Opus 102, D major, "Retrospection."

Opus 102, C major, "Faith."

"But the Lord Is Mindful of His Own," from "St. Paul."

"Sieben Charakterstücke," Opus 7, Fugue V, Andante VI.

Concerto, G minor, Andante.

Mozart, Wolfgang A.

Sonatas

2nd movement

- C Major (K. 279), Andante.
- C Major (K. 545), Andante.
- C Major (K. 330), Andante cantabile.
- F Major (K. 280), Adagio.
- B Flat Major (K. 281), Andante.
- A Minor (K. 310), Andante cantabile con espressione.
- D Major (K. 311), Andante con espressione.
- B Flat Major (K. 333), Andante cantabile.
- B Flat Major (K. 570), Adagio.

Fantasia and Sonata (K. 475); fantasia, Andantino; sonata, Adagio.

Concertos

- A Major, Andante (2nd movement).
- D Major, Larghetto (2nd movement).
- B Flat Major, Andante (2nd movement).

Nevin, Ethelbert.

"The Rosary."

Offenbach, Jacques.

"Barcarolle," intermezzo from the opera "Les Contes d'Hoffmann."

Rubinstein, Anton.

- "Romance," Opus 44, No. 1.
- "Kamennoi-Ostrow," Opus 10, No. 22.

Saint-Saens, Camille.

- "The Swan." (Le Cygne, melody from the "Carnaval des Animals.")
- "My Heart at Thy Sweet Voice," from "Samson and Delilah"

Schubert, Franz.

- "The Stars."
- "La Sérénade" (Ave Maria).
- Impromptu, Opus 142, No. 2.
- "Moment Musical," Opus 94, No. 6.
- Symphony, B minor ("Unfinished"), Allegro moderato (Schirmer No. 1408; "Analytic Symphony Series No. 4," Ditson).

Schumann, Robert.

- "Träumerei," Opus 15, No. 7.
- "Nocturne," Opus 23, No. 4.
- "The Unanswered Question," Opus 68, No. 30.
- "Evening Song," Opus 85, No. 12.
- "Romance," Opus 68, No. 2.
- Concerto, A minor, Andante espressivo in 1st movement, intermezzo.

Sibelius, Jean.

"Finlandia" (Century No. 3236; "Analytic Symphony Series No. 14," Ditson).

Sullivan, Sir Arthur.

"The Lost Chord."

Tschaikowsky, Peter Ilyitch.

"Chanson Triste," Opus 40, No. 2.

Symphonies

No. 5, E minor, theme from the 2nd movement ("Analytic Symphony Series No. 30," Ditson).

No. 6, B minor ("Pathétique"), theme from the 1st movement ("Analytic Symphony Series No. 7," Ditson).

Opus 23, Concerto No. 1 in B Flat Minor, Andantino semplice.

Thome, Francis.

"Simple Confession."

"Berceuse," E flat major.

Wagner, Richard.

"O Thou Sublime, Sweet Evening Star," from "Tannhäuser."

Special Compilations.

"Church and Chapel Voluntaries for Piano," compiled by A. G. Driesbach (Schirmer).

"Classics for the Church Pianist," compiled by Lucile Earhart (Presser).

"Sabbath Day Music for the Piano," compiled by John Carroll Randolph (Ditson).

For a postlude, patients enjoy hymns such as "Onward, Christian Soldiers" played at a rather fast tempo. These may be played one after the other and about two times each. Music should continue until all patients have left the chapel.

APPENDIX IV

LIST OF VISUAL AIDS

The following list of visual aids can be used to supplement some of the material in this book. This list, although subdivided by chapters, is a comprehensive rather than a selective list. Therefore, we would suggest that each film be previewed before using as some may contain information that is too advanced while others may contain information that is too elementary.

These films can be obtained from the producer or distributor listed with each title. (The addresses of producers and distributors are given at the end of the bibliography.) In many cases these films can be obtained from your local film library or local film distributor; also, many universities have large film libraries from which they can be borrowed.

The running time (min) and whether it is silent (si) or sound (sd) are listed with each title. All of the motion pictures are 16mm black-and-white films.

Each film has been listed once in connection with the chapter to which it is most applicable. However, in many cases the film might be used advantageously in connection with other chapters.

CHAPTER I—PSYCHIATRIC NURSING: MEANING AND OBJECTIVES

Balloons: Aggression and Destruction Games (NYU 20min sd). This is a study of aggression and destruction in young children.

Finger Painting (NYU 30min si). Shows the responses of nine children from three to six years of age in using paints; contributes to the understanding of personality.

Frustration and Play Technique (NYU 40min sd). A study of ego development and response to frustration.

This is Robert (NYU 80min sd). Shows a comprehensive treatment of an aggressive "difficult" child over a period of five years; the development of particular behavior traits and the alteration under trained guidance are documented.

CHAPTER IV—NURSING CARE: PRIMARY PERSONALITY DISORDERS

A Nurse's Day with the Mentally Ill (PCR 30min si). Presents some of the duties and techniques of psychiatric nursing.

Symptoms of Schizophrenia (PCR 14min si). Illustrates a summary of the symptoms in schizophrenia.

The Treatment of Mental Disorders (PCR 17min si). Shows case interview-

ing, various diagnostic and therapeutic procedures, occupational therapy and recreational management in the hospital.

Narcosynthesis (PCR 18min si). Deals with the use of drugs as an aid in psychotherapy.

Convulsive Shock Therapy in Affective Psychoses (PCR 15min si). From a nursing point of view, this film is particularly valuable in showing patient behavior before and after treatment.

Athetoid Gestures in a Deteriorating Parergasic (Schizophrenic). (PCR 6min si MP). Shows gestures that suggest athetosis, but the evidence of patterns which suggest symbolic meaning and the repetition of patterns in various combinations point to something different.

Catatonic Behavior in a Deteriorated Parergasic (Schizophrenic) Patient (PCR 5min si). Shows significant posture and ritualistic and stereotyped behavior.

A Parergasic Reaction (Schizophrenia) in a Person of Low Intelligence (PCR 50min sd). Presents an interview between the psychiatrist and the patient; contributes material for the observation and understanding of behavior.

Psychiatry in Action (BIS 60min sd). Deals with the treatment of functional neuroses.

Psychoneuroses (NYU 23min si). Shows signs and symptoms of this illness; also, clinical syndromes suggestive of organic disease.

Experimentally Produced Neurotic Behavior in the Rat (PCR 22min si). Demonstrates causes of neurotic behavior in animals.

Abortive Behavior as an Alternative for the Neurotic Attack in the Rat (PCR 14min si). Deals with neurotic behavior in the rat.

The Dynamics of an Experimental Neurosis: Its Development and Techniques for Its Alleviation (PCR 4 parts si).

Part I Conditioned Feeding Behavior and Induction of Experimental Neuroses in Cats (15min). Deals with simple conditioned response learning and production of neuroses in animals.

Part II Effects of Environmental Frustrations and Intensification of Conflict in Neurotic Cats (15min). Deals with the factors which intensity neurotic behavior in cats.

Part III Experimental Diminution of Neurotic Behavior in Cats (15min). Deals with treatment of neuroses in animals.

Part IV Active Participation in Establishing More Satisfactory Adjustment (15min). Deals with treatment of neuroses in animals.

Dominance, Neurosis, and Aggression in Cats (PCR 30min si). Illustrates the effect of loss of dominance and of induced neurosis upon aggressive behavior.

The Dynamics of Competition in Cats: Intercat Relationships in a Matripalliative Feeding Situation (PCR 13min si). Presents a social food-getting situation shows the development of patterns of cooperation, conflict, dominance, and active and passive parasitism which resemble those seen in interhuman relationships.

The Effects of Morphine on Learned Adaptive Behavior and Experimental Neuroses in Cats (PCR 15min si). Suggests a parallelism between the observations and drug addiction in human beings.

336 NURSE-PATIENT RELATIONSHIPS IN PSYCHIATRY

Neurosis and Alcohol: An Experimental Study (PCR 22min si). Deals with cats; suggests some interesting principles on the dynamics of alcoholism.

The Role of the Hypothalamus in Emotion and Behavior (PCR 22min si). Deals with the physiology of emotion.

The Effects of Electrical Stimulation and Destruction of the Hypothalamus in the Cat (PCR 20min si). Deals with organic changes in emotion.

The Effects of Various Drugs on the Emotional Mimetic Reactions of the Hypothalamus and Cerebral Cortex of the Cat (PCR 16min si). Deals with the effect of drugs on some of the neural mechanisms involved in emotion; drugs used—alcohol, metrazol, morphine, sodium amyta.

Experimental "Neurosis" in a Dog (PCR 8min si). Deals with experimental neuroses; shows the importance of environment in treatment; compares a neurotic dog with a stable animal.

CHAPTERS V AND VI—NURSING CARE: SPECIAL PROBLEMS

Help Wanted (TFC 33min sd). Shows the basic principles of first aid.

First Aid (TFC 11min sd). Demonstrates basic procedures.

Before the Doctor Comes, Part I, How to Control Bleeding—Care of Shock (Iowa 11min sd). Presents chart of arteries; shows how to control bleeding; demonstrates care for shock victims.

Before the Doctor Comes, Part 2, Artificial Respiration—How to Care for Burns (Iowa 11min sd). Presents proper methods for administering artificial respiration; describes procedures for treating light, extensive, and chemical burns.

Feeding the Patient (USOE 15min sd). Explains physical, mental, and emotional factors which affect appetite and digestion; deals with the proper balance of food and nutritional needs.

CHAPTER VII—NURSING CARE: REHABILITATION

The Road to Health and Happiness (Iowa 14min si). Deals with public health problems including mental habits.

Posture (Iowa 14min si). Deals with good posture, factors influencing posture, the importance of good posture in physical well-being.

The Feet (Iowa 14min si). Deals with the arches, the mechanical use of the foot and shoes.

Posture and Exercise (Iowa 11min sd). Describes and illustrates muscle activity and the physiology of exercise.

Posture for Poise (Iowa 22min si). Shows natural situations in which posture is important, thus illustrating the practical side of the posture problem.

Digestion of Foods (EBF 11min sd). Presents both the mechanical and chemical aspects of digestion together with their controlling factors.

Foods and Nutrition (EBF 11min sd). Presents normal dietary requirements; illustrates metabolism of carbohydrates, fats, and proteins.

Fundamentals of Diet (EBF 11min sd). Deals with the uses of food in the human body; the major classes of foods in an ideal diet and their special contribution to body welfare.

CHAPTER VIII—NURSING CARE: SECONDARY PERSONALITY CHANGES

The Nervous System (EBF 11min sd). Shows the structure of the nervous system, particularly in man, its pathways and connections.

The Dissociative Effects of Curare (PCR 9min si). Deals with dogs; shows the effects of curare on the nervous system.

Carotid Sinus Syndrome (PCR 12min si). Deals with a carotid sinus sensitivity causing syncope or convulsions; shows a patient before and after operation.

Huntington's Chorea (PCR 8min si). Shows motor characteristics of this disease.

Paranoid State and Deterioration Following Head Injury (PCR 10min sd). Presents a physician-patient interview; demonstrates patient's dominant notions of persecution.

Delusions and Hallucinations in a Senile Setting (PCR 4min sd). Shows a patient who thought he had invented a new method of communication demonstrating his powers, both sending and receiving.

A Case of Aphasia (PCR 11min sd). Presents a psychiatric examination of a case of speech interference; unusually clear demonstration of symptoms.

Chorea (NYU 16min si). Gives a brief outline of the three groups of chronic degenerative chorea: Huntington's, arteriosclerotic, and postencephalitic.

Convulsive and Allied Conditions (NYU 18min si). This film includes convulsive state in hypoglycemia and convulsions of psychogenic origin as well as other well-known convulsive conditions.

Epidemic Encephalitis (NYU 31min si). Presents several cases each one showing some particular feature of the sequelae of epidemic encephalitis.

CHAPTER IX—THE USE OF ART, LITERATURE, MUSIC

Alice Adams—Dance (NYU 20min sd). Deals with an adolescent girl and a particular problem relating to the behavior toward each other of people in different economic groups.

Alice Adams—Money (NYU 20min sd). Shows family problems because of a lack of money; Alice's sensitiveness to appearances and how it influences her behavior and relationship with a young man.

Animal Kingdom (NYU 20min sd). Illustrates personal problems growing out of a premarital experience.

As the Twig Is Bent (NYU 11min sd). Shows the effect of home environment on child development.

Captains Courageous—School (NYU 11min sd). Deals with study and guidance of a "spoiled" child at home and in school; presents a study of money in relation to happiness.

Captains Courageous—Fishhook (NYU 11min sd). Shows the place of affection in the control of behavior of a "spoiled" child and the way adult behavior patterns set examples for children.

Cradle Song (NYU 11min sd). Reveals the dangers of and reasons for possessive and selfish parental love.

338 NURSE-PATIENT RELATIONSHIPS IN PSYCHIATRY

I Am a Fugitive from a Chain Gang—Chain Gang (NYU 20min sd). Deals with a study in frustration.

I Am a Fugitive from a Chain Gang—Parole Board (NYU 20min sd). Presents a study in frustration.

The Informer (NYU 20min sd). Reveals the need for money as motivation in behavior that leads to subsequent unhappiness.

La Maternelle (NYU 20min sd). Presents a study of a neglected child and her attempts at compensation.

SOURCES OF FILMS LISTED ABOVE

BIS—British Information Services, 30 Rockefeller Plaza, New York 20.

Castle Films, Inc., 30 Rockefeller Plaza, New York 20.

EBF—Encyclopaedia Britannica Films, Inc., 20 N. Wacker Dr., Chicago 6.

Iowa—State University of Iowa, Iowa City, Iowa.

NYU—New York University Film Library, Washington Sq., New York 3.

PCR—Psychological Cinema Register, Pennsylvania State College, State College, Pennsylvania.

TFC—Teaching Film Custodians, 25 W. 43 St., New York 18.

USOE—U. S. Office of Education (Obtainable from Castle Films, Inc.).

Index

A

- Accidents, 7, 168-173, 179, 255
and nursing care, 168-173
prevention of, 168-172
 in aged, 286
reports of, 171-173
 examination of, 172
Admission procedure, of patient, 88, 91-94
Advice, thoughtless, to patient, 102
Affective indifference, 140-150
 description of, 140-142
 nursing care in, 144-150
 physical changes in, 142
 types of, 144
 verbal aberrations in, 142-144
Aggressive behavior, of patient, 103, 120, 121, 127, 174-187
and abuse in hospitals, 186
and extreme excitement, management of, 184-186
 prevention of, 174-178
and head nurse, 186, 187
 nursing care in, 174-186
Alcoholic psychosis, 270-274
 delirium tremens, 271-272
 hallucinosis, acute, 274
 Korsakoff's psychosis, 273
Alzheimer's disease, 285
Anxiety, definition of, 51
Anxiety state, 155
Art, use of, in understanding patient, 296-298
Arteriosclerosis, cerebral, with psychosis, 278-281
Attention, 45, 52, 53
Attention tests, 52
Auditory aids, in remedial approach, 122

B

- Beauty, therapeutic use of, 95, 106, 116, 117
Behavior, in adolescence, 73, 74
 definition of, 42
and parental attitudes, 73-75
pathological (symptomatic), aggressive (*see Aggressive behavior*)
combative (*see Combative behavior*)
 definition of, 42
impersonal characteristic of, 71
modification of, 14, 17, 26, 27, 79-83, 88, 98, 104, 124
motivation of, 74, 94
objective, 43, 45-61, 70
observation of, 43-67
in primary personality disorders, 126
recording, 57-67
subjective, 13, 43, 44, 70-71, 254
types of, 127-128
 overactive, 127
 seclusive, 128
 underactive, 127
understanding, 67-79
unpredictable, 13, 80, 81
utilizing, 117, 132
patterns of, 74, 77
vital needs in, 77
Bibliography, on art, use of, 311-312
on behavior, 83-87
on literature, use of, 311-312
on music, use of, 311-312
on nursing care, in primary personality disorders, 163-167
problems of, 226-227
in rehabilitation, 256-258

Bibliography, on nursing care, in
remedial approach, 124-125
in secondary personality changes,
291-295

Biotherapy, 242, 243

Body, and mind, unity of, 54, 68

C

Calculation tests, 52

Central therapy, 230

Combative behavior, 103, 120, 121,
127, 133, 174, 180, 183
prevention of, 120, 121, 133

Compulsion, 45, 50, 51
definition of, 51

Compulsive act, 51

Compulsive ritual, 51, 155

Conflict, inner, 154-156

Confusion, definition of, 52

Constipation, 189, 256

Contributory therapy, 230-248

Conversation, therapeutic use of, 25,
106, 107, 113-115, 130, 152,
157

D

Defeat, by patient, 117, 120

Delirious mania, 134

Delirium, 52, 195, 272

Delirium tremens, 271-272

Delusion, 45, 50, 53, 120, 130, 153,
176, 195, 290

definition of, 50

of persecution, 140, 151, 175, 222,
274

Dementia praecox (schizophrenic re-
action), 126, 140
(*See also* Affective indifference)

Depression (manic-depressive psycho-
sis, depressed phase), 126, 134-
140
with agitation, 89, 134, 139-140

degrees of, 135

description of, 134, 135

nursing care in, 135-139, 140

symptoms of, 135

"Depth" psychology, 69
Discipline, salutary, 121, 123
Distrust, by patient, 17
Drugs, sedative (*see* Sedative drugs)

E

Education, formal, therapeutic use
of, 246, 247

Elation (manic-depressive psychosis,
manic phase), 128-134
degrees of, 129
description of, 128, 129
nursing care in, 129-134
symptoms of, 129

Elimination, and bladder, 188

and bowels, 189

enuresis in, 191

incontinence in, 190, 191

nursing responsibility for, 187-
191

records of, 191

and skin, 188

untidiness in, 190, 191

Emotional immaturity, 18, 302,
303

Emotional maturity, 4, 5, 73

Emotional needs of patient, anticipa-
tion of, 106, 110

Encephalitis, epidemic, with psycho-
sis, 269-270

Environmental factors, in mental ill-
ness, 77
in sleep, 214, 215

Environmental stimuli, in mental ill-
ness, 133

Epilepsy (*see* Psychosis, due to con-
vulsive disorders)

Escape, of patient, 191-194, 223

methods of, 191

prevention of, 192-193

record forms for, 194

responsibility for, 191

and return, 194

Excitement, of patient, 6, 56, 129,
131, 133, 174-178, 281
prevention of, 174-178

Exhaustion, signs of, 133

F

- Fatigue, signs of, 134, 209, 232
 Fear, definition of, 51
 reactions to, 89
 reduction of, 88-90
 and selfishness, 110
 and sleeplessness, 211, 214
 symptoms of, 155
 Fecal impaction, 189, 256
 Feeling tones, of patient, 31
 transfer of, 27, 28, 32, 91-95, 100,
 112, 113, 122, 123, 134, 177,
 184, 211, 249
 Fluid intake, 200
 Food (*see* Nutrition)
 Freud, Sigmund, 68

G

- Glossary of psychiatric terms, 46-50,
 321-327
 Gustatory aids, in remedial approach,
 122

H

- Habit training, of patients, 24, 147,
 233-235, 249, 250
 in affective indifference, 147
 Hallucination, 45, 50, 53, 120, 176,
 195, 199, 274
 definition of, 50
 Hallucinosis, acute, 274
 Head nurse, responsibilities of, for
 behavior chart, 58
 in disturbed ward, 186-187
 for planned programs, 158
 regarding suicide, 225
 Hospitalization, in depression, 139
 in elation, 134
 Human nature, vital needs of, 77
 Hygiene, mental, definition of, 307
 oral, 138
 Hygienic measures, 137, 178, 233,
 250
 Hypochondriasis, 155
 Hysteria, 155

I

- Ideas, flight of, 129
 of influence, 45, 50, 175
 of persecution, 45, 50, 51
 of reference, 45, 50
 Incontinence, definition of, 190, 191
 in syphilitic meningoencephalitis,
 266
 Influence, ideas of, 45, 50, 175
 "Insanity," 44
 Insight, 45, 53
 Interest, of patients, search for, 106,
 112, 148
 stimulating, 88, 94-96

J

- Judgment, by patient, 45, 53, 73

K

- Korsakoff's psychosis, 273, 285
 Kraepelin, Emil, 68n.
 Kraepelinian period, 68

L

- Library, hospital, 243
 Literature, use of, in understanding
 patient, 298-308
 (*See also* "Madame Bovary")
 Logic, 72
 Love, mature, 73

M

- "Madame Bovary," outline for study
 of, 313-320
 Manic-depressive psychoses (*see* De-
 pression; Elation)
 Melancholy stupor, nursing care of,
 139
 Memory, 45, 52, 53
 Mental deficiency, with psychosis,
 nursing care in, 162
 Mental hygiene, definition of, 307
 Mental illness, causes of, 1, 78

Mind, and body, unity of, 54, 68
 Mood, 14, 17, 26, 27, 45, 49–50, 53,
 79, 80, 88, 104, 124, 131, 138
 modifying, 14, 17, 26, 27, 79, 88,
 98, 104, 124
 rigidity of, 80
 variations in, 131, 138
 Music, for piano, in church services,
 310, 328–333
 radio, 309
 therapeutic use of, 240, 308–310

N

Negativism, 118, 141
 Nervous system, function of, 42
 Neurasthenia, 155
 Neuroses (*see Psychoneuroses*)
 Nurse, as companion, 23, 27, 28
 energy requirements of, 253–254
 function of, 9, 10, 54, 228
 qualifications of, 3–9, 18, 96–101
 responsibilities of, in bibliotherapy,
 243
 regarding escape, 191–194
 in nutrition, 201
 in physical education, 241
 in recording behavior, 43–54,
 57
 for sleep, 208
 regarding suicide, 249
 Nurses' notes (ward notes), 61, 65,
 66
 Nursing activities, direct, 14, 88
 immediate, 14–16, 88
 over long period, 17, 88
 outstanding, 13
 Nursing care, in accidents, 168–173
 in affective indifference (schizo-
 phrenic reaction), 144–150
 in aggressive behavior, 174–186
 in contributory therapy, 232
 in convalescence, following depres-
 sion, 138, 139, 224
 following elation, 134
 in delirious mania, 134
 in delirium due to trauma, 275–277
 in delirium tremens, 271–272

Nursing care, in depression (manic-
 depressive psychosis, depressed
 phase), 135–139
 with agitation, 140
 in elation (manic-depressive psy-
 chosis, manic phase), 129–134
 in elimination, 187–191
 in epileptic clouded states, 283–284
 in epileptic deterioration, 282
 evaluation of, 255
 in excitement, 133, 174
 and fluid intake, 200
 in hallucinosis, acute, 274
 in Korsakoff's psychosis, 273
 in melancholy stupor, 139
 in overactivity (hyperactivity), 127
 in personality disorders, primary,
 126–167, 260
 due to trauma, 278
 and prevention of undesirable be-
 havior, 121
 in psychoneuroses (neuroses), 156–
 160
 in psychoses, with arteriosclerosis,
 cerebral, 279–281
 due to drugs, 274
 with encephalitis, epidemic, 270
 with mental deficiency, 162
 with psychopathic personality,
 161
 senile, 286–291
 with syphilis, cerebral, 268
 meningoencephalitic, 265–267
 in rehabilitation, 228–258
 in remedial approach, 88–125
 in return of escaped patient, 194
 in seclusion of patient, 180–183
 in seclusive behavior, 128
 in secondary personality changes,
 126, 260
 in seizures, 204–207
 in senile psychoses, 286–291
 in sleep, 208–221
 in suspicion (paranoia), 151–153
 in syphilis, cerebral, 268
 in syphilitic meningoencephalitis,
 265–267
 and timing, 118

Nursing care, in underactivity (hypomania), 127

- on wards, 249-255
- admission, 249, 254
- convalescent, 252-255
- disturbed, 250, 254
- infirmary, 250, 254
- medical, 249-250, 254
- quiet, 250-251, 254
- research, 253
- surgical, 249-250, 254

(*See also Psychiatric nursing*)

Nursing needs, 18, 296

Nursing objectives, 23-39, 43, 79, 88, 91, 251, 252

Nutrition, in depression, 7, 138, 139

- in elation, 132
- and fluid intake, 200
- and forced feeding, 201
- problems of, 195-201
- and refusal of food, 17, 195-199
- and undernourishment, 201
- and weight, 201

O

Observation, of pathological behaviour, 43-57

- of patient as a person, 35-38
- of seizures, 205-208

Obsession, 45, 50, 51

- definition of, 51

Obsessive-compulsive act, 51

Occupational therapy, 235-239

Olfactory aids, in remedial approach, 122

Orders, specific, by physician, 14, 23, 25, 88, 120, 130, 131, 135, 146, 151, 156

- in affective indifference, 146
- in depression, 135
- in elation, 130, 131
- in psychoneuroses, 156
- in suspicion, 151

Orientation, 45, 52

Overactivity (hyperactivity), nursing care of, 127

P

Paranoia, 126, 150

Patient, comfort for, 20, 25-26

- holding, 132, 185

- needs of, 106-117

- observation of, 35-38

- as person, a, 10, 13, 20, 34-39, 79, 99, 101, 104-107, 110, 112, 113, 149, 256

- physical condition of, 54-57

- posture of, 240

- refusal by, avoidance of, 119

- rights of, 103-106

- security for, 89

- as teacher, 19

Persecution, ideas of, 45, 50, 51

Personality changes, secondary (*see Secondary personality changes*)

Personality disorders, primary, 126-167

Phobia, 45, 50, 51

- definition of, 51

Physical condition, of patient, 54-57

Physical education, 239-241

- definition of, 239

Physician, conferences with, 23, 25, 157, 252

- orders by (*see Orders, specific, by physician*)

Physiotherapy, 242

Piano, compositions for, 328-333

Posture, of patient, 240

Primary personality disorders, 126-167

Projection, 45, 50

- definition of, 50

Psychasthenia, 155

Psychiatric disorders, 126-128

Psychiatric nursing, 1-41, 42, 55, 69, 80, 97, 99, 107, 109, 121, 124, 262

- compensations of, 19

- concepts of, essential, 10

- and general nursing, 6, 12, 20-23, 27, 80, 95, 118, 159, 208

- intelligence in, use of, 99

- meaning of, 1-23

- Psychiatric nursing, objectives in, 23-39
 problems of, practical, 5, 13, 25, 33, 94, 233, 256
 success in, 17, 18, 124
 teaching, 256
(See also Nursing care)
- Psychoneuroses (neuroses), 89, 126, 153-160, 278
- Psychopathic personality, with psychosis, nursing care in, 161
- Psychosis, due to alcohol, 261, 270-274
 with arteriosclerosis, cerebral, 261, 278-281
 due to convulsive disorder (epilepsy), 261, 282-284
 definition of, 126
 due to drugs, 261, 274
 with encephalitis, epidemic, 261, 269-270
 with mental deficiency, 126, 162
 due to neoplasm, 262
 with psychopathic personality, 126, 160-161
 senile, 284-291
 with syphilis, meningoencephalitic (general paresis), 261, 263-267
 meningovascular (cerebral), 261, 267-268
 due to trauma, 261, 275-278
- Psychosomatic condition, tonus to, 68
- R
- Rapport, 26, 102, 103, 107, 114, 118, 176, 187, 249
- Reasoning, by patient, 45, 53, 73
- Recording behavior, 57-67
- Records, accident, 172
 behavior, 43, 57-64
 elimination, 191
 escape, 194
 occupational therapy, 239
 required activity, 67
 sleep, 217
 suicide, 225
- Records, in ward notes (nurses' notes), 61, 65-67
- Recreational therapy, 241
- Reference, ideas of, 45, 50
- References (*see Bibliography*)
- Rehabilitation, 228-258
 bibliography on, 256-258
 meaning of, 228
 program required for, 228
 therapeutic goal of, 229
- Relatives, of patient, 8, 9, 192, 201-204
 attitude of, 201-204
 evaluation of, 203
- Religious activities, value of, 242
- Remedial approach, activities in, 117-123
 admission procedure in, use of, 91-94
 auditory aids in, 121-122
 bibliography on, 124-125
 "don'ts" in, 101-103
 and fear, reduction of, 88-91
 gustatory aids in, 122
 and interest, arousing, 94-96
 meaning of, 88
 and nurse's behavior, 96-101
 objectives of, 88
 olfactory aids in, 122
 and patient's needs, 106-117
 and patient's rights, 103-106
 tactful aids in, 123
 visual aids in, 121-122
- Resocialization, 243-246
- Restlessness, as symptom of trouble, 176
- Restraint, of patient, 183, 256
- S
- Schizophrenic reaction, 126, 140
(See also Affective indifference)
- Seclusion, of patient, 179, 180, 182, 183
- Seclusion room, 180-182
- Seclusive behavior, nursing care of, 128
- Secondary personality changes, 126, 259-295

- Secondary personality changes, bibliography on, 291-295
classification of, 261, 262
conditions in, acute, 260
chronic, 260
diagnosis of, primary physical, 259
nursing care of, 126, 260
study of, approach for, 262
symptoms of, 259
treatment of, 260
- Sedative drugs, 217-221, 283
and nursing points, 217
types of, 218-221
barbiturates, 218-220, 283
bromides, 218, 283
chloral hydrate, 220
paraldehyde, 220
- Seizure, in convulsive disorders, 282, 284
nursing care in, 205-208
nursing responsibility in, 204
in pathological states, 204
as symptom, 204
tests for sensitivity to, 205
types of, 204, 205
- Senile psychoses, 284-291
- Senses, therapeutic appeal to, 121-123
- Sensorium, and intellectual reactions, 45, 52, 53
- Shock, symptoms of, 172
- Sleep, in aged, the, 287
amount of, 215
in depression, 138
disturbances in, 221
in elation, 132
and nursing duties, 209-217
nursing responsibility for, 208
problems of, 208-221
promoting, 209-211
quality of, 216, 217, 255
and rest, 209
sedative drugs for, 217-221
value of, 208
- Social service activities, 247-248
- Speech, by patient (stream of talk), 45, 48-49, 53
- Suicide, 128, 136, 138-140, 146, 152, 160, 191, 221-225, 249, 253, 267, 270, 274, 284
attempted, 225
and depression, 136, 138, 140
legal responsibility for, 222
methods of committing, 222
nursing points on, 223-225
nursing responsibilities for, 225
occurrence of, 221
prevention of, 128, 136, 222
problems of, 221-225
reasons for, 222
records of, 225
and syphilitic meningoencephalitis, 267
and underactivity, 128
on wards, admission, 249
convalescent, 253
- Suspicion (paranoia), 150-153
nursing care in, 151-153
symptoms of, 151
- Symptomatic behavior (*see Behavior, pathological*)
- Symptoms, of exhaustion, 133
onset of, 1
of personality disorders, primary, 126-129
of physical illness, 44, 55-57, 127
of secondary personality changes, 259
of shock, 172
- Syphilis, meningoencephalitic, with psychosis, 263-267
cerebral, with psychosis, 267-268
- T
- Tactual aids, in remedial approach, 123
- Talk, by patient, stream of, 45, 48-49, 53
- Teamwork, in rehabilitation, 229
- Temperature, of ward, 121, 123
- Therapeutic activities, kinds of, 230
nursing responsibilities in, 232
- Therapeutic program, 7, 232
- Therapy, central, 230

Therapy, contributory, 230-248

occupational, 235-239

recreational, 241

Trauma, delirium due to, 275-277

personality disorders due to, 278

U

Underactivity (hypoactivity), nursing care in, 127

Understanding pathological behavior
(*see* Behavior, pathological, understanding)

Untidiness, 190-191

Unwholesome attitudes (*see* Psycho-neuroses)

V

Ventilation, 121, 123

Visual aids, in remedial approach, 121-122

list of, 334-338

Vital needs, of human nature, 77

W

Ward, admission, 249, 254

atmosphere of, 28, 32, 214, 272

convalescent, 121, 252-255

disturbed, 2, 6, 179, 250, 254

infirmary, 250, 254

medical, 249-250, 254

quiet, 2, 121, 250-251, 254

research, 253

routines of, 23, 24, 147

surgical, 249-250, 254

Ward notes (nurses' notes), 61, 65, 66

Weight, of patient, 54, 55, 57, 127, 132, 138, 142, 146, 201, 266

in affective indifference, 142,

146

in depression, 55, 138

in elation, 132

in syphilitic meningoencephalitis, 266

Form No. 3.

PSY, RES.L.I.

**Bureau of Educational & Psychological
Research Library.**

The book is to be returned within
the date stamped last.

616.89
REN
Form No. 4

BOOK CARD

Coll. No. **616.89** Accn. No. **633**
Author **Render, Helena W.**
Title **Nurse-patient relationships in psychiatry**

Date.	Issued to	Returned on
.....

616.89
REN